Kathryn Miller, LCSW, BCD
Certified Anger Therapist

The Conference Center
22 Parman Place, San Antonio, TX 78230
www.kathrynmillertherapy.com

PATIENT HISTORY FORM

Name:		Date:	

Chief Concern:

Prior Treatment:

Have you ever received psychological or counseling services before? ☐ Yes ☐ No

If yes:

When?	From whom?	For what?	With what results?

Have you ever taken medications for psychiatric or emotional issues? ☐ Yes ☐ No

If yes, please list medications taken, the time period taken, and the results:

_____

_____

_____

_____

_____

Abuse History

Have you ever been abused physically, emotionally, or sexually? ☐ Yes ☐ No

If yes, what type of abuse?

_____

Relationships

How do you get along with your present spouse or partner?

_____

How do you get along with your children and/or your parents?

_____

How do you get along with people you know?

_____

How do you get along with strangers or new people?

_____

Substances

How much beer, wine, or liquor do you consume in an average week?

How much tobacco do you smoke or chew each week?

Which drugs (not medications prescribed to you) have you used in the last 10 years?

Which drugs have you used, how much, how often, and what were their effects?

Other

Please share anything else that you feel is important to your treatment.