

Body & Soul Therapy®

2045 Maybank Hwy., Charleston, SC 29412 • 843-795-1100

Patient History Form

Date_____ Social Security #_____ Referred by_____

Name_____ DOB____/____/____ Age____ Sex____
(First) (Last) (Middle Initial)

Address_____ (Number and Street) (City and State and Zip Code)

E-mail address/ home_____ E-mail address/work_____

Telephone: Day _____ Evening____ \ _____ Cell_____

Health insurance company_____ Policy ID and Group #_____

Policy Holder_____ DOB____/____/____ Place employed_____
(First) (Last) (MI)

Marital status: Single____ Married____(How long?_____) Separated____(How long?_____)
Divorced____ (How long?_____) Widowed____(How long?_____)

Living with?_____ # of children?_____ #of Siblings?_____

Hobbies/Interests/Strengths?_____

Last year of schooling completed_____ Occupation_____

Name/address of employer_____

_____ Telephone_____

Your spouse/partner's occupation/employer?_____

Family history of addictions, emotional/mental problems? _____

Are you receiving or seeking disability? _____ Type? _____

Previous psychotherapy? _____ Why? _____ When? _____

Therapist name, address and telephone number _____

Name and telephone number of your physician _____

Have you ever had a seizure, serious brain concussion or a stroke? _____

Current and chronic illnesses? _____

Current medications? _____ Last physical exam? _____

Current/Previous Symptoms _____ Sleeping Problems? _____ Eating Problems? _____ Anger?

_____ Sexual Problems? _____ Use of Alcohol/Recreational Drugs? _____ Worries/Fears?

_____ Suicidal Thoughts/Attempts _____ History of Physical/Emotional/Sexual Abuse?

_____ Learning Problems? _____ Trauma? _____ Physical Problems? _____ Addictions?

Explain: _____

Reason for seeking counseling? _____

Person to reach in case of an emergency: _____ Relationship? _____

Telephone number: Day _____ Evening _____