KINGS COUNSELING CENTER

808 N. IRWIN STREET
HANFORD, CA 93230

Roger A. Watson, M.F.T. and Associates
Marriage, Family and Child Therapy
Psychotherapy

PATIENT ASSESSMENT FORM

For Office Use
Patient ID #_____

DATE: _____

PATIENT #1 NAME:_____ DATE OF BIRTH: _____ AGE: _____ **GENDER**: M F

OCCUPATION: _____ **SCHOOL / GRADE**: _____

PHONE: H: _____ C: _____ (May a counselor leave a message at either of these numbers? Y N)

EMERGENCY CONTACT: _____ **RELATIONSHIP**: _____ **PHONE**: # _____

PATIENT #2 NAME: _____ **DATE OF BIRTH**: _____ **AGE**: _____ **GENDER**: M F

PHONE: H: _____ C: _____ OCCUPATION: _____

PARENT'S NAME IF PATIENT IS A MINOR: _____ **RELATIONSHIP**: _____

WILL THIS INVOLVE LITIGATION? (Constituting any sort of lawsuit) Y / N

INSURANCE COMPANY _____, EAP YES / NO, NUMBER OF VISITS _____

PRIMARY PHYSICIAN: _____ **PHONE #**: _____

ARE YOU CURRENTLY SEEING ANOTHER PSYCHOTHERAPIST? Y / N

IF YES, PLEASE WRITE THE NAME AND PLACE OF PRACTICE: _____
_____

REFERRED BY: _____

MARITAL STATUS:

MARRIED _____ SEPARATED _____ DIVORCED _____ SINGLE _____ ENGAGED _____ OTHER _____

HEALTH RELATED ISSUES

1. ARE YOU PRESENTLY TAKING ANY FORM OF DRUGS / MEDICATION? (Circle one) Y N
2. ARE THESE PRESCRIBED BY A DOCTOR? (Circle one) Y N * Name of Physician _____
3. LIST ALL DRUGS / MEDICATIONS AND DOSES: _____
   _____
4. LIST ANY ALLERGIES OR ADVERSE REACTIONS TO MEDICATIONS: _____
   _____
5. WOULD YOU LIKE YOUR THERAPIST TO CONSULT WITH YOUR PHYSICIAN REGARDING YOUR PSYCHOLOGICAL ISSUES? Y N (Release of Information form must be signed)
6. RATE YOUR HEALTH: (Circle one) EXCELLENT GOOD / AVERAGE DECLINING POOR
7. APPROXIMATE WEIGHT: _____ LBS.
8. LIST RECENT WEIGHT CHANGES: _____

9. LIST ANY INJURIES OR ILLNESSES (PAST AND PRESENT) THAT CURRENTLY AFFECT YOUR LIFESTYLE:
_____
_____

10. LIST ANY ALLERGIES: _____

11. HAVE YOU EVER HAD ANY SERIOUS EMOTIONAL EPISODES? (Circle one) Y N
DESCRIBE: _____
_____

12. DATE OF LAST MEDICAL / PHYSICAL EXAM: _____
RESULTS: _____

13. HAVE YOU EVER BEEN UNDER THE CARE OF A PSYCHIATRIST OR PSYCHOTHERAPIST? (Circle one) Y N
DATES: _____

14. OTHER PERTINENT HEALTH INFORMATION: _____

15. SLEEP PATTERNS: HOW MANY HOURS DO YOU SLEEP EACH NIGHT? _____

TIME YOU GO TO BED: _____ TIME YOU FALL ASLEEP: _____

TIME YOU WAKE UP: _____ TIME YOU GET OUT OF BED: _____

NUMBER OF TIMES YOU WAKE UP DURING THE NIGHT: _____

THERAPEUTIC QUESTIONS:

16. WHAT DO YOU HOPE TO GAIN FROM THERAPY?

17. WHEN DID YOUR CURRENT CONCERNS BEGIN?

18. WHAT FACTORS CONTRIBUTE TO THESE CONCERNS?

19. WHAT HAVE YOU DONE TO TRY TO WORK THROUGH THESE CONCERNS?

20. WHAT PEOPLE IN YOUR LIFE COMPOUND THESE ISSUES?

21. ARE THEY AWARE OF THEIR ROLE IN YOUR CURRENT CONCERNS?

22. WHAT HAVE YOU DONE THAT HAVE MADE THINGS WORSE?