The Hart Center Mental Health: Patrick J. Hart Psy.D.
3727 Bagley Avenue North. Seattle Washington 98103 206-547-HELP

Client's Contact Information and Mental Health History

Client's name: ________________________________ Date: _______________

Address: ____

City, State: ____________________________________ Zip: _______________

Phone numbers ***with area code*** Home: (   )_______________________

Work: (   ) ________________ Cell: (   ) _______________ Email________________

Birth date: ______________ Age: ___ Social Security Number: ______________________

Employer: ____

Position: ____ For how long?__________

Education: ____

Marital/relationship status: ___________ Significant other's name: _______________

Significant other's age and sex: _________ How long together? ___________________

Names and ages of children in the home: ____

How did you hear about Dr. Hart's practice? __________________________________

Who shall we contact in case of emergency?

Name & Relationship: ______________________________ Phone (   ) _______________

In this box, please indicate the address and telephone number you want me to use when sending bills or when I need to contact you. If this box is left blank, I will use the address and any of the telephone numbers you have provided above. If you do *not* want me to leave a message on your answering machine, please tell me at which phone number you want to be reached so I can assure your privacy:

I hereby consent for Dr. Hart to provide mental health counseling services for me.

____

Signature   Date

What problems or challenges do you want to resolve as a result of counseling or therapy?

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Medical and Mental Health History

List any current medical issues: ______________________________ None____

Primary Care Physician: __________________Address:____________________

City:_________________________ State:_________ ZIP:__________

Primary Care Physician's phone number: (___) _________________________

Date of your most recent physical examination:_________________________

List all current medical treatment or medications and the dosage prescribed:

Name of Medication or Nature of Treatment	Dosage Tx Plan	Name of Prescribing Health Practitioner	Does this Medicine Help?

Please list any traumatic life experiences or other events that seem important:
(for example: assaults, episodes of abuse, domestic violence, accidents or disasters)

Current Psychological & Social Stress	Past Experiences Relevant to Therapy

List all therapists you have employed and approximate dates you saw them: →

Summarize previous counseling or psychological help you have received:

Mental Health Practitioners and Prior Treatment Programs You Have Explored	Diagnosis And Appx Date	Was This Helpful?
Counselor:		
Psychologist:		
Psychiatrist MD:		
Psychiatric Hospitalization		
Formal Substance Abuse Treatment Program		
Legally Mandated Mental Health Care		
Legally Mandated Inpatient Drug Treatment		
Other Relevant Self Help Programs AA, NA, Etc		

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What is your primary goal for counseling and Psychotherapy with Dr. Hart?

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Please indicate if you are currently experiencing any of the following problems, or if you had such challenges in the past:

	Current	Past
It seems like my thoughts are "racing"	____	____
I am sleeping so much that I get little accomplished	____	____
I have experienced a change in appetite, weight loss, or weight gain	____	____
I experience frequent crying spells that interfere with my goals	____	____
I have panic attacks or debilitating anxiety	____	____
I have thoughts of suicide or frequently want to die	____	____
I have made attempts to kill myself	____	____
I have problems with concentration or memory	____	____
I am concerned about substance abuse	____	____
I experience daily sadness lasting more than two weeks	____	____
I startle easily and am "jumpier" that most people	____	____
I can't stop remembering upsetting past events	____	____
I have difficulty managing anger & controlling my temper	____	____
I physically hurt other people or lash out violently	____	____
I break things sometimes and act out impulsively	____	____
I worry a lot about things that I cannot control	____	____
I have little or no interest in sex	____	____
I feel more tired than I find acceptable	____	____
I believe I am phobic and have irrational fears	____	____
I make myself throw up in order to lose weight	____	____
I have homicidal ideas that command revenge	____	____
I have self-cutting or self-mutilating behavior	____	____
I have stopped doing things that I used to enjoy	____	____
I worry that something is wrong with my body	____	____
I frequently argue with the people I live with	____	____
I hear voices inside my head that tell me what to do	____	____
I feel pressured inside and wonder if I am bipolar	____	____

Please summarize other relevant concerns or psychological challenges below:
(Feel free to make use of the backs of these pages. Please describe everything you want me to know so that I can help you to achieve the outcomes you desire as a result of our counseling process. Take you time and write as much as you wish!)

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Signature **Date**