FRANCES M. BLEDSOE, LCSW
Psychosocial/Medical Information

Name_____ Date_____Age_____
Do you have a preferred pronoun by which you like to be addressed, i.e. "he, she, none" etc.?_____

Are you currently in a relationship with a significant other(s)? _____If yes, please check below:
Married_____Living with significant other____
In committed monogamous relationship living separately_____; In open relationship _____
Length of time together as a couple_____
Currently separated_____
Or if your relationship doesn't fit any of the above categories, please describe:
_____
Or I am not in a relationship at this time_____Dating?_____
Number of children:_____Ages:_____

Persons living in your household:	Relationship:	Ages:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Employment/Occupation:_____How long?_____
Do you like your work?_____ Number of jobs in the past 5 years:_____
Years of education completed or degrees:_____
Religion (optional):_____
Any current or past legal problems? Yes_____ No_____If you answered "yes", please explain:

Past (Outpatient) Psychotherapy

Dates		Therapist name	Where
From	To		

Was it helpful to you?_____
Have you ever been hospitalized for any psychiatric or chemical dependency issues? Yes_____No_____
If yes, please give dates, facility name, and a brief treatment summary:_____
_____-
_____
_____
Have you ever been prescribed medication for emotional issues (such as depression, anxiety, insomnia) in the past? Yes_____No_____. If yes, please list medications, when prescribed and **by whom**:_____

Please circle any medications listed above which you are taking at the present time.
Was/Is the medication helpful?_____
_____

_____ _____
(signature) (date)

I like to make a point of contact letter to your Primary care provider or psychiatrist if you have one. (A contact letter consists of my saying I have seen you, who I am, and how to contact me should you provide a release of information for us to talk later if needed.) If you agree that I may do that, please fill in and sign below for each person you would like me to contact:

I give permission for Frances M. Bledsoe, LCSW, to contact:

_____

(practitioner) (office address) (phone)

for the purpose of informing only that I am in treatment with her. Valid until_____

(date of your choice/ usually one yr.)

I give permission for Frances M. Bledsoe, LCSW, to contact and share information to and from:

_____

(practitioner) (office address) (phone)

the purpose of informing only that I am in treatment with her. . Valid until_____

(date of your choice/ usually one yr.)

Have you ever attempted suicide?_____
If yes, please explain when, circumstances, method, etc:_____

Have you had suicidal thoughts or plans within the last year?_____ If yes, please note circumstances, method planned etc.:_____

Are you currently experiencing suicidal thoughts or plans?_____

Have you ever had problems with aggressive or rageful behavior?_____If yes, please explain circumstances:_____

Are you currently experiencing urges to hurt or kill someone else?____ If yes, please explain:_____

_____ _____

(signature) (date)

Do you:
Drink alcohol? Yes_____No_____**Specifically,** how often?_____
How much each time?_____Age of first drink_____
Drink caffeinated beverages? Yes____No_____ How many and how often?_____
Use drugs "recreationally"? Yes_____No____
What drugs?_____
_Dosages_____Frequency _____
Do you think you have ever had a problem with alcohol or drugs?_____
Do others think that you have a drinking or drug problem?_____
Have you ever had relationship, work, or legal problems due to substance abuse?__(If "yes" please explain)_____

Past or current significant physical illnesses, surgeries, hospitalizations, miscarriages, etc, and approximate dates:_____

Significant emotional or medical problems in current family or loved ones:_____

Any other important current or past information relevant to your decision to be here:_____

If you make the changes you would like to as a result of participating in psychotherapy, how will you be different?_____

What do you like best about yourself?_____

_____ _____
(signature) (date)

Please circle any conditions listed below that you've had or are currently experiencing and note when.

Condition	Approx. date of onset	Experiencing now?	Frequency
Anxiety symptoms/attacks			
Phobias			
Loss of appetite			
Increase of appetite			
Loss of interest in activities			
Fatigue/loss of energy			
Feelings of hopelessness			
Insomnia			
Excessive sleeping			
Significant mood swings			
Obsessive thinking or behavior			
Sense of being out of your body			
Black outs/ missing time			
Hearing voices/seeing visions			
Anorexia			
Bulimia			
Compulsive or binge eating			
Body image distortion			
Compulsive drinking			
Compulsive drug use			
Compulsive spending			
Compulsive Gambling			
Pulling out your hair			
Cutting on yourself			
Compulsive sexual activity, affairs, (or compulsive use of pornography or internet pornography)			
Workaholism (more than 45 hrs/wk)			
Smoking cigarettes			
Excessive TV (more than 4 hrs/day)			
Computer play more than 4 hrs/day			
Have been sexually abused or harassed			
Have sexually abused someone else			
Have been physically abused			
Have physically abused someone else			
Have been (significantly) verbally abused			
Continually verbally abusive to others			
Stress due to cultural biases (against race, sexual orientation, weight, religion, disability, finances, etc.)			
Bereavement (about):			
_____			
_____			
Other Conditions/ Concerns:			
_____			
_____			
_____			

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_____ (signature)

_____ (date)