Michelle Kan-Braceras, LPC
3920 Market St. Camp, Hill PA 17011
717.516.LIFE (5433)

Personal Information and History **Date**:_____

Name: _____ Date of Birth: _____ Age_____

Address:_____

Preferred phone number: _____ Ok to leave messages?: __yes __no

Secondary number: _____ Ok to leave messages?: __yes __ no

Marital Status: ____Single ____Married ___Divorced _____Separated ____Living with Partner

Referral to treatment made by: _____

Type of Medical Insurance: _____

Policy #: _____

Past Mental Health History: Problem/ Issue Provider Dates Type of Treatment

1._____
_____
_____

2._____
_____
_____

3._____
_____
_____

Medical History

Primary Care Physician:_____

Address/Phone_____

Medical Issues/ Diagnosis:

1. _____
2. _____
3. _____

Have you had any surgeries in the past? Yes/No

If Yes, Please list:_____
_____

Medications:Name Dosage / Frequency/ Prescribed by

1._____
2._____
3._____
4._____
5._____

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Do you have any allergies to food or drugs? Yes/ No

If yes, please list:_____

Educational/ Vocational History:

Current occupation: _____

Are you satisfied with your current occupation? Yes/ No/ Unsure

Highest educational level completed: _____

Drug and Alcohol History Please place a checkmark beside all substances used.

	Yes/No	**Amount**	**Frequency**	**Last used**
Cigarettes				
Alcohol				
Sedatives				
Caffeine				
Painkillers				
Marijuana				
Crack/Cocaine				
Heroine				

Are you concerned with your use of any of these substances? Yes/ No

If Yes- please elaborate_____

Do you have any personal/ family history of:

Psychiatric Illness: _____

Psychiatric Hospitalizations: _____

Suicide attempts: _____

Self- Injurious Behavior_____

Alcohol or Drug Issues/ Addictions: _____

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Family info:

Children? No Yes How many?_____

Siblings? No Yes How many? _____

How would you say you get along with your children/partner?

_____

_____

How would you say you get along with your family of origin (parents, siblings etc.)?

_____

_____

Symptoms:

Are you currently experiencing overwhelming sadness, grief, or depression? ___ No _____ Yes
If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks, or have any phobias? ____ No ____ Yes
If yes, when did you begin experiencing this? _____

Are you currently or have you recently experienced suicidal or homicidal thoughts?__ No __Yes

Have you experienced any significant life changes or stressful events recently? ___ No
____Yes If yes, please describe:

_____

_____

_____

Have you been experiencing any of the following symptoms:

Depressed mood/sadness	Irritability	Feelings of guilt	Withdrawn
Lack of concentration	Fatigue/loss of energy	Excessive Worry	Loss of interest in previous hobbies
Weight change	Change in sleep	Physical symptoms (ex-headaches, stomachaches etc.)	Other:

Trauma History:

History of abuse? (verbal, physical, sexual): _____

Other trauma? (please specify:) _____

_____

_____

_____

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What would you like to achieve in counseling? Do you have any specific goals?

Any further details/ information that you feel would be helpful for me to know for your treatment:

Thank you for taking the time to complete this form. Please let me know if there are any questions or clarifications that you need.

Michelle Kan-Braceras, LPC, NCC

*****THERAPIST WILL COMPLETE*****

Diagnoses and Treatment Plan

Axis I: _____

Rule out: _____

Treatment Plan

Issue	Goals	Treatment