Sound Foundations
Professional Counseling
Where the building blocks
Of future successes are laid
Jason Soto MA, MFT
Individual, Couples & Family Therapist

Please complete this form as it pertains to the client.

Why are you here today?:

How long has this been going on? ☐ less than 6 months ☐ more than 6 months

Previous Psychiatric History

Have you received mental health services before? ☐ No ☐ Yes ☐ Voluntary ☐ Involuntary If yes, where and when:

Have you ever had a psychiatric hospitalization? ☐ No ☐ Yes ☐ Voluntary ☐ Involuntary If yes, where and when:

Is there a family history of psychiatric problems? ☐ No ☐ Yes If yes, please explain:

Medical Information

Do you have any current medical problems? (Please list)

Have you had any major medical problems in the past? (Please describe)

Who is your current medical provider:

When did you last see him/her?

Would you like us to contact your medical provider regarding your presence in treatment? ☐ Yes ☐ No

Please list all current medications (including non-traditional medications i.e., herbs, vitamins, over-the-counter, other):

Medication Name	Dosage/Time	Reason	Prescriber	Currently Taking?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Do you have allergies? ☐ No ☐ Yes

List allergies (include food and medications) and the type of reaction experienced:

1. 3.
2. 4.

Substance Use: ☐ N/A

☐ Caffeine: Amount: Frequency: Duration:
☐ Tobacco: Amount: Frequency: Duration:
☐ Alcohol: Amount: Frequency: Duration: Type:
☐ Prescription Drugs(abuse only): Amount: Frequency: Duration: Type:
☐ Inhalants(abuse only): Amount: Frequency: Duration: Type:
☐ Illegal drugs, type: Method of Administration:
Other:

Please List Family/Household Members:

Name	Age	Relationship to client	Where living
			☐ At Home ☐ Out of the home
			☐ At Home ☐ Out of the home
			☐ At Home ☐ Out of the home
			☐ At Home ☐ Out of the home
			☐ At Home ☐ Out of the home
			☐ At Home ☐ Out of the home
			☐ At Home ☐ Out of the home
			☐ At Home ☐ Out of the home

Please list other important people involved in your life:

Spiritual/Religious Activity: ☐ No ☐ Yes, Specify:

Education: ☐ Graduate degree ☐ Undergraduate ☐ Associate/Vocational/Tech Degree ☐ High School/GED
☐ Less than High School Specify last grade completed: _____

Special education (specify subjects):

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