Dr. Renee M. Winters
Depth Psychologist & Life Coach

Marriage & Family Therapist PhD, LMFT

Dr. Renee M. Winters, PhD, MFT #51788

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❖ Patient Information

Name _____ Today's Date _____
Address _____
Home phone _____ Work phone _____
Cell phone _____ E-mail _____
Social Security # _____ Driver's License # _____
Gender M F Age _____ Date of birth _____
Marital status _____ Educational level _____
Names and ages of children_____

** Emergency contact information _____

Responsible Party if the patient is an underage minor.
Name _____
Who is the legal guardian? _____
Address: _____
Home phone _____ Cell phone _____
Social Security # _____ Driver's License # _____
What type of legal paperwork do you possess for minor? _____

❖ Employment Information

Employer _____ Occupation _____
Address _____
Employed Full Time _____ Part Time _____ Unemployed with benefits _____
Years at Employer _____ Gross Income _____

Annual household income _____ Do you own or rent? _____
How do you intend to pay for treatment? (cash, check, charge, insurance) _____

If planning to use health insurance:
Name of insurance company _____
Policy number _____ Group number _____
Telephone number _____ Annual Deductible _____
CoPay_____

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❖ **Personal History**

Ethnicity _____ Primary Language _____
Was the patient adopted? Yes _____ No _____
Lived at any time in foster care? Yes _____ No _____
Is the patient in school? Yes ____ No ____ Name of school/college _____

Spouse/Partner's Name _____
Length of relationship _____ Married/Separated/Divorced _____
Date of birth _____ Age _____ Gender M F
Address (if different than above) _____
Home phone _____ Cell phone _____
Social Security # _____ Driver's License # _____
Employer _____ Occupation _____
Years employed _____ Annual Gross Income _____

❖ **Areas of Concern**

What issues/concerns causes you to seek treatment? Please describe. _____
_____

❖ **Referred By? How did you hear about me?**
_____

PLEASE SIGN BELOW TO INDICATE THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT:

_____ _____
Signature of Client **Date**

_____ _____
Signature of Parent/Legal Guardian/Other **Date**
(Required if patient is a minor, under age 18)

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❖ Psychological History

Have you ever received mental health treatment before? _____
When and for how long? _____
What was the focus of treatment? _____
Name of treating therapist(s), address(es), telephone number(s) _____
_____
Have you ever been subjected to one or more psychological tests? _____
If so, by whom? _____
Name of person(s) administered psychological tests, address(es), telephone number(s)
_____

Inform patient that authorization for release of confidential information will be needed so that any test administrator may be contacted.
Have you ever been hospitalized for mental or emotional problems? _____
When and for how long? _____
Why were you hospitalized? _____
Name of treating therapist, address, telephone number _____
Inform patient that authorization for release of confidential information will be needed so that any former therapists may be contacted.
Are you currently taking any prescription medications? _____
Prescribed by whom? _____
How long have you been on the medications? _____
Have you ever taken any medications for a mental or emotional condition? _____
When and for how long? _____
Inform patient that authorization for release of confidential information will be needed so that health care provider may be contacted.
Have you ever attempted suicide? _____
When? _____
Describe the circumstances that led to that attempt. _____
_____
_____
Are you currently having any suicidal thoughts? Please describe _____
_____
_____
Please describe your childhood. _____
Were you ever subjected to verbal, physical, emotional, sexual abuse? Please describe.
_____
_____
Have you ever been a victim of a violent crime? Please describe _____
_____
_____

❖ **Medical History**

Have you ever been diagnosed with a serious illness? Please describe _____
_____
_____
Do you have any medical conditions that may affect your mental health treatment? _____
Please describe your overall health today. _____
Patient Questionnaire/Intake 4
_____
Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe. _____
_____
_____
Have you ever been in a 12-step program? Please describe. _____
_____
Do you smoke? _____ How much? _____ For how long? _____
Do you drink alcohol? _____
On average, how much alcohol do you consume in a week?_____
Do you currently use illegal drugs? Please describe your use _____
_____
Have you ever used illegal drugs? Please describe. _____
_____
Family of Origin History
Mother's name, age, living/deceased, patient's age at the time of mother's death, description of relationship with mother. _____
_____
_____
Father's name, age, living/deceased, patient's age at the time of father's death, description of relationship with father. _____
_____
_____
Names and ages of siblings. _____
_____
Other Information
Please describe your spiritual identity/orientation. _____
Please describe your interests/hobbies _____
Are you now or have you ever been involved in a lawsuit? _____
Please describe. _____
_____
Please feel free to include any other information that you believe is relevant to your mental health treatment, not previously requested. _____
_____
_____