Michael W. McNulty, LPC
760 Old Roswell Road, Suite 352
Roswell, GA 30076

770-289-8217
Mike@MikeMcNultyLPC.com

PATIENT BACKGROUND FORM

Today's date: _____

Your name: _____
Last **First** **Middle Initial**

Date of birth: _____ Place of birth _____

What are your concern(s)? _____
_____
_____

What are your goals for therapy? _____
_____
_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _____

MEDICAL HISTORY

Please explain any significant medical problems, symptoms, or illnesses: _____
_____
_____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? YES NO If YES, how much per day? _____
Do you consume caffeine? YES NO If YES, how much per day? _____
Do you drink alcohol? YES NO If YES, how much per day/week/month/year? ____
Do you use any non-prescription drugs? (Please remember that this form is completely confidential).
YES NO If YES, what kinds and how often? _____
_____
Previous Hospitalizations: (Approximate dates and reasons):_____
_____
Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO
(Please list approximate dates and reasons): _____
_____
_____

FAMILY

How would you describe your past and present relationship with your mother?
_____
_____
_____

Michael W. McNulty, LPC
760 Old Roswell Road, Suite 352
Roswell, GA 30076
770-289-8217
Mike@MikeMcNultyLPC.com

How would you describe your past and present relationship with your father?

_____
_____
_____

Are your parents still married?_____ If they divorced, how old were you when they separated or divorced, and how did this impact you? _____
_____

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: _____
_____

How many sisters do you have? _____ Ages? _____
How many brothers do you have? _____ Ages? _____
How would you describe your relationships with your siblings? _____
_____
_____

RELATIONSHIP STATUS

POOR EXCELLENT
Currently in Relationship? ____ How Long? ____ Relationship Satisfaction: 1 2 3 4 5 6 7
Married/Life Partnered? _____ How Long? _____ Previously Married/Life Partnered? YES NO
If so, length of previous marriages/committed partnerships_____
Do you have children? ___ If YES, how many and what are their ages:_____
Describe any problems any of your children are having: _____

EDUCATION

Attending school now? _____ If YES, name of school: _____
Degree or diploma held: _____ Last school attended: _____
What is/was your experience of school/college: _____
_____
_____

LEGAL ISSUES

Have you ever been convicted of a crime? ___ Yes ___No
If yes, please describe _____
_____

Have you ever been incarcerated? ___Yes ___No
If yes, please describe the location and length of incarceration(s)_____
_____

Any additional information you would like to include:

_____
_____
_____
_____

Michael W. McNulty, LPC
760 Old Roswell Road, Suite 352
Roswell, GA 30076

770-289-8217
Mike@MikeMcNultyLPC.com

AREAS OF DIFFICULTY

Check all that apply. CIRCLE the main issue.

Difficulty with:	Now	Past	Difficulty with:	Now	Past	Difficulty with:	Now	Past
Anxiety			People in General			Nausea		
Depression			Parents			Abdominal Distress		
Mood Changes			Children			Fainting		
Anger or Temper			Marriage/Partnership			Dizziness		
Panic			Friends			Diarrhea		
Fears			Co-workers			Shortness of Breath		
Irritability			Employer			Chest Pain		
Concentration			Finances			Lump in Throat		
Headaches			Legal Problems			Sweating		
Loss of Memory			Sexual Problems			Heart Palpitations		
Excessive Worry			History of Child Abuse			Muscle Tension		
Feeling Manic			History of Sexual Abuse			Pain in Joints		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often Make Careless Mistakes		
Drugs			Hurting Self			Fidget Frequently		
Alcohol			Thoughts of Suicide			Speak Without Thinking		
Caffeine			Sleeping Too Much			Waiting Your Turn		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Blackouts			Head Injury			Chills / Hot Flashes		

FAMILY HISTORY

Check all that apply.

- ☐ Drug / Alcohol Problems
- ☐ Legal Trouble
- ☐ Domestic Violence
- ☐ Suicide
- ☐ Physical Abuse
- ☐ Sexual Abuse
- ☐ Hyperactivity
- ☐ Learning Disabilities
- ☐ Depression
- ☐ Anxiety
- ☐ "Nervous Breakdown"
- ☐ Psychiatric Hospitalization