Rachel Mathew, LCSW
Turning Point Psychotherapy, PLLC
6845 Fairview Road, Charlotte, NC 28210

Personal Information

Referral Source:

Medical professional Insurance provider Friend/family

Psychology Today Website Other

Educational History:

Check the highest level completed
( ) Elementary School ( ) High School ( ) College ( ) Graduate School ( ) Other

If currently studying, name institution _____

Work History:

Source of Income: Full-Time Employment Part-Time Employment Unemployed

Full-Time Student Part-Time Student Disability SSI

Current Occupation: _____ Name of Employer: _____

Have you served in the military? Y N

Have you had any significant problems holding down a job? _____

_____

Have you had problems at your current job or previous job? _____

_____

Relationship Status (please check one)

Single Married Separated/Divorced Widowed Unmarried Couple Partnered

Current Family History (Present household members, family (incl. children))

Name and Relationship Age Medical/Mental Health/Substance Abuse History

Do you have any significant relationship problems? _____

_____

If married how would you rate your relationship with your spouse on a scale of 1-10? _____

If you have children, how is your relationship with them? _____

_____

Family of Origin History (Parents, siblings, extended family who resided in the same house)

Name and Relationship Age Medical/Mental Health/Substance Abuse History

How would you rate your relationship with your parents and siblings on a scale of 1-10? _____

Significant Medical History _____

_____

_____

_____

Do you suffer from chronic pain? Y N

If yes, please state condition _____

Please list any medications and dosages you are currently taking:

_____

_____

_____

_____

Have you ever been hospitalized for a medical reason? Y N

If hospitalized, state where, when and why _____

_____

Name of Primary Care Physician: _____

Name and address of practice: _____

_____

How would you rate your current physical health?

Poor Unsatisfactory Satisfactory Good Very good

How would you rate your current sleeping habits?

Poor Unsatisfactory Satisfactory Good Very good

If you are having sleep problems, in which phase of sleep?

Falling asleep Staying asleep Waking up early Sleep apnea

How many times per week do you exercise? _____

What types of exercise do you participate in? _____

Has there been any change in weight over the past year? _____

Have you ever suffered from any eating problems? _____

Are you or have ever been under the care of a psychiatrist? Y N

If yes, who _____ when _____

State reasons _____

Have you ever been in outpatient therapy? Y N

If yes, where, when and for what reason(s)? _____

_____

Have you ever been hospitalized for mental health problems? Y N

If so, where, when and for how long? _____

_____

Have you ever been suicidal or had suicidal ideations? _____

_____

Have you ever been a victim of physical/sexual/emotional abuse? _____

_____

Have you ever been treated for any addiction problems (alcohol, drugs, gambling, pornography, etc.) _____

_____

Do you currently have any addiction problems? _____

_____

Have you ever been arrested or served jail time? _____

Have you suffered any significant loss or trauma? _____

_____

Are you currently experiencing extreme sadness, depression and or anxiety? _____

_____

Please describe briefly presenting concern: _____

_____

_____

_____

What do you hope to get out of therapy? _____

_____

_____

Do you practice any specific faith or are you spiritual? If so, please describe. _____

_____

_____

What would you describe as your greatest strengths? _____

_____

_____

Who constitutes your support system? _____

_____

What do you enjoy doing the most? _____

_____

How do you relieve stress? _____

_____

What do you do for fun and to relax? _____

_____

_____ _____

Signature Date