Therapy Integration Practices, Inc.
Ph (253) 804-9596 Fax (253) 351-8960
Gaaren Anderson, LMFT, LMHC

CLIENT____________________**#**____
Patient__________________________

HISTORY

Date_______

MEDICATIONS (Include current changes)

Condition	Medication	Dosage + When to When

ALLERGIES

MEDICAL HISTORY

(Major illnesses, injuries, surgeries, conditions, prenatal/postnatal difficulties, etc)

PREVIOUS THERAPY

COUNSELING / Psychiatric / ChemDependency Tx
(Incl. approx dates, Provider, Problem, Outcome)

When	What

DEVELOPMENTAL HISTORY

Academic History—(circle highest level attained)

--Elementary
--Middle School
--High School
--College/Technical
--Graduate School

TRAUMA / RISK / Significant Events

Events which have caused stress (job changes, moves, deaths in family, Suicide attempts, loss of relationship, Physical/Sexual Abuse, etc)

When	What