Boston Evening Therapy Associates, LLC
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# Relevant Personal History

Thank you for contacting BETA. To better serve your needs please complete this form prior to your first visit.

Date:_____

Name: _____ Date of Birth: _____
Address:_____
Home Phone:_____ Cell Phone: _____
Email: _____

Emergency Contact: _____
Relationship: _____
Phone:_____

Have you seen a therapist before? Yes or No (please circle)

Please indicate which of the following you have experienced.

| | | |
|---|---|---|
| ☐Depression | ☐Self-Harm | ☐PTSD |
| ☐Anxiety | ☐Academic Challenges | ☐Abuse |
| ☐Grief | ☐School Refusal | ☐Relationship |
| ☐Eating Disorder | ☐Sexual Identity | ☐Addiction/Substance Use |
| ☐Trauma | ☐ADHD | ☐Bullying |
| ☐Anger Management | | |
| ☐Other: _____ | | |

Have you been hospitalized in the past? Yes or No (please circle)
If yes, the date:
_____

Are you currently taking medication? Yes or No (please circle)
If yes, please list the current medications you are taking:
_____

Name of Prescriber:
_____

Do you have a Primary Care Physician? Yes or No (please circle)
Name of Primary Care
Physician:_____
Address:_____
Phone:_____

Is there anything else that you would like your therapist to know to better serve your needs?
_____
_____

Last Update: 06/13/15