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: _____
DOB:_____

Address:_____
Phone:_____

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	☐Sexual Identity
☐Anxiety	☐ADHD
☐Grief	☐PTSD
☐Eating Disorder	☐Abuse
☐Trauma	☐Relationship
☐Self Harm	☐Addiction/Substance Use
☐Academic Challenges	☐Bullying

☐**School Refusal** ☐**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? Y 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?
_____
_____