

Please provide the following information for my records. Leave blank any question you would prefer not to answer. Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session or allow yourself 30 minutes prior to your appointment to complete the form in the office.

Client's name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if client is a minor):

(Last) (First) (Middle Initial)

Birth Date: ____ / ____ / ____ Age: ____ Gender: Male Female

Local Address: _____
(Street and Number)

(City) (State) (Zip)

Home Phone: (____) _____ - May I leave a message? Yes No

Cell/Other Phone: (____) _____ - May I leave a message? Yes No

E-mail: _____ May I email you? Yes No

* Please be aware that email is not confidential. I will use it only for scheduling purposes.

How did you find out about my services?:

Are you receiving psychiatric services (medication), professional counseling or therapy elsewhere?

Yes No If yes, current provider's name: _____

Have you been in therapy before?

Yes No If yes, previous therapist's name: _____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?

Yes No If yes, please list:

Have you previously been prescribed psychiatric medication?

Yes No If yes, please list:

What are you seeking help for today?

How are your above issues affecting your ability to function effectively?

What are your goals for therapy?

What are effective coping strategies are you using now?

What do you consider to be your strengths/What do you like most about yourself?

Any additional information that would help me in understanding your concerns or problems:

CURRENT ISSUES

Please indicate which of the following issues/problems *you would like to address in therapy*:

- | | |
|---|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Body image problems |
| <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Lack of friends | <input type="checkbox"/> Traumatic events |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Victim of abuse (physical or sexual) |
| <input type="checkbox"/> Suicide thoughts/attempt | <input type="checkbox"/> Grief/loss |
| <input type="checkbox"/> Homicidal thoughts | <input type="checkbox"/> Problems at work/school |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Family conflict |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Alcohol/substance abuse |
| <input type="checkbox"/> Anxiety/panic attacks | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Phobias | _____ |

In the PAST have you ever experienced:

- | | |
|---|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Body image problems |
| <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Lack of friends | <input type="checkbox"/> Traumatic events |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Victim of abuse (physical or sexual) |
| <input type="checkbox"/> Suicide thoughts/attempt | <input type="checkbox"/> Grief/loss |
| <input type="checkbox"/> Homicidal thoughts | <input type="checkbox"/> Problems at work/school |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Family conflict |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Anxiety/panic attacks | _____ |
| <input type="checkbox"/> Phobias | _____ |
| <input type="checkbox"/> Alcohol/substance abuse | |

PERSONAL AND FAMILY HISTORY

<u>Relationship</u>	<u>Name</u>	<u>Age</u>	<u>Living</u>		<u>Living with you</u>	
			<u>Yes</u>	<u>No</u>	<u>Yes</u>	<u>No</u>
Mother	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spouse	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other significant people in your life (e.g., girlfriends/boyfriends, brothers, sisters, grandparents, step-relatives, half-relatives)

<u>Relationship</u>	<u>Name</u>	<u>Age</u>	<u>Living</u>		<u>Living with you</u>	
			<u>Yes</u>	<u>No</u>	<u>Yes</u>	<u>No</u>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your relationship status (more than one answer may apply)

Single/dating Unmarried, living together Married Divorced Divorce in process

Other _____

If yes, how long have you been in this relationship? _____

Length of time married: _____ Total number of marriages: _____

On a scale of 1-10, how would you rate the quality of your current relationship?

1 2 3 4 5 6 7 8 9 10

Comments/concerns about the quality or frequency of your sexual life:

Parental Information: Were *your* parents

Parents legally married Parents have ever been separated Parents ever divorced

Father remarried Mother remarried

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.): _____

Family Mental Health History:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following?:

<input type="checkbox"/> Depression	<input type="checkbox"/> Suicide Attempts	Other: _____
<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Trauma History	_____
<input type="checkbox"/> Anxiety Disorders	<input type="checkbox"/> Eating Disorders	_____
<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Learning Disabilities	_____
<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Alcohol/Substance Abuse	_____

Childhood:

Were there any special, unusual, or traumatic circumstances that affected you as a child?

Yes No

If yes, please describe: _____

Have you experienced child abuse? Yes No

If yes, which type(s)? Sexual Physical Verbal

If yes, were you the: Victim Perpetrator Witness

Other childhood issues: Neglect Inadequate nutrition

Other (please specify): _____

Other significant information: _____

SOCIAL RELATIONSHIPS

Check how you generally get along with other people: (check all that apply)

Affectionate Aggressive Avoidant Fight/argue often Follower

Friendly Leader Outgoing Shy/withdrawn Submissive

Other (specify): _____

Sexual orientation: _____ Comments: _____

OCCUPATIONAL/SCHOOL INFORMATION:

Are you currently employed?

Yes No If yes, who is your current employer/position?

If yes, are you happy at your current position?

Are you currently a student?

Yes No If yes, school's name and current year/grade:

Please list any work-related/school stressors, if any: _____

HEALTH INFORMATION

How is your physical health at present?

Poor Unsatisfactory Satisfactory Good Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

Are you having any problems with your sleep? Yes No

If yes, check where applicable:

Sleeping too little Sleeping too much Poor quality sleep

Disturbing dreams Other _____

How many times per week do you exercise? _____

Approximately how long each time? _____

Are you having any difficulty with appetite or eating habits? Yes No

If yes: Eating less Eating more Binging Restricting

Have you experienced significant weight change in the last 2 months? Yes No

