PERSONAL INFORMATION & HISTORY

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All information you provide here is held to the same standards of confidentiality as our therapy. Leave blank any question you would rather not answer. Please fill out this form prior to our first session.

Client Name _____

Address _____ City_____ Zip Code _____

Preferred e-mail contact:_____

Phone: Hm _____Wk _____ Cell _____ Which would you prefer? _____

May I leave a message at hm? _____ wk? _____ cell? _____

Age _____ Birthdate ____/____/_____

Number, ages, & gender of children_____Where do they live?_____

Employer/Occupation _____

Work Address _____ City_____ Zip Code _____

Contact in case of emergency: _____ Phone number _____

Please state the nature of your main concern: _____

_____

_____

Please rate how serious this concern feels to you: (Circle one) **Mild** 1 2 3 4 5 6 7 8 9 10 **Severe**

How long have you been experiencing this concern? _____

COUNSELING HISTORY AND RELATED INFORMATION

Are you currently receiving psychiatric services, counseling or psychotherapy elsewhere? ☐ Yes ☐ No
If Yes, with whom? _____

Have you had previous counseling or psychotherapy? ☐ Yes ☐ No
Previous therapist's name_____
Please describe your experience: _____
_____

Are you currently taking prescribed psychiatric medication (antidepressants, etc)? ☐ Yes ☐ No
If Yes, please list: _____
If no, have you been previously prescribed psychiatric medication? ☐ Yes ☐ No
If Yes, please list: _____

Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No
If yes, when? _____ Length of hospital stay? _____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

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

3. Are you having any problems with sleep? ☐ Yes ☐ No

If yes, please explain: _____

4. How many times **per week** do you exercise? _____ Approximately how long each time? _____

5. Are you having any difficulty with appetite or eating habits? ☐ Yes ☐ No
If yes, check where applicable: ☐ Eating less ☐ Eating more ☐ Binging ☐ Restricting
Have you experienced significant weight change in the last 2 months? ☐ Yes ☐ No

6. Do you smoke or use tobacco? ☐ Yes ☐ No Please describe: _____

Do you regularly use alcohol? ☐ Yes ☐ No Please describe: _____
If yes, in a typical month, how much do you spend on alcohol? _____

How often do you use other/recreational drugs? ☐ Daily ☐ Often ☐ Rarely ☐ Never ☐ Not any more
If at all, please describe: _____

7. Have you had suicidal thoughts recently? ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

Have you had them in the past? ☐ Yes ☐ No

8. Are you currently in a romantic relationship? ☐ Yes ☐ No
If yes, how long have you been in this relationship? _____
On a scale of 1-10, how would you rate the quality of your current relationship? _____

Have you been engaged or married prior to this relationship? ☐ Yes ☐ No
If yes, please describe: _____
_____

9. Current relationship status (please circle):

Never married Separated Living together Married Divorced Widowed

10. What of the following have you experienced in the **past year**? (check all that apply)

Anger Management Issues	☐	Memory Impairment	☐
Anxiety	☐	Obsessions/Compulsions	☐
Chronic Pain	☐	Parenting Issues	☐
Depression	☐	Phase of Life Problems	☐
Eating Disorder	☐	Restlessness	☐
Educational Problems	☐	Sexual Dysfunction	☐
Family Conflict	☐	Sleep Disturbance	☐
Financial Problems	☐	Social Discomfort/Shyness	☐
Grief/Loss	☐	Spiritual Confusion	☐
Intimate Relationship Conflict	☐	Substance Abuse	☐
Legal Problems	☐	Trauma (physical/emotional)	☐
Loneliness	☐	Vocational Stress	☐
Major Life Change	☐		
Medical Issues	☐		

Other (specify): _____

FAMILY MENTAL HEALTH HISTORY:

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

Difficulty:	Family Member(s):	Received treatment?
Depression ☐ Yes ☐ No		
Bipolar Disorder ☐ Yes ☐ No		
Anxiety Disorders ☐ Yes ☐ No		
Panic Attacks ☐ Yes ☐ No		
Schizophrenia ☐ Yes ☐ No		
Alcohol/Substance Abuse ☐ Yes ☐ No		
Eating Disorders ☐ Yes ☐ No		
Learning Disabilities ☐ Yes ☐ No		

Trauma/Abuse History ☐ Yes ☐ No _____
Suicide Attempts ☐ Yes ☐ No _____

FINANCIAL INFORMATION (used for sliding scale fees):

Approximate annual household income: _____
Size of household (adults & dependents): _____
Significant financial stressors: _____

OCCUPATIONAL/EDUCATIONAL INFORMATION:

Are you currently employed? ☐ Yes ☐ No
Status: ☐ Full-time ☐ Part-time
If yes, are you happy at your current position? _____

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

Education (Highest grade completed - please circle):

0-5 6-8 9-12 GED High School College degree Graduate degree

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? ☐Yes ☐ No
If yes, what is your faith? _____
If yes, do you feel that your faith should be a significant part of your therapy? ☐Yes ☐ No
Please describe: _____
If no, do you consider yourself to be spiritual? ☐Yes ☐ No
Please describe: _____

GOALS/EXPECTATIONS

What goal(s) would you like to accomplish through counseling? _____
_____
_____

OTHER INFORMATION

What do you consider to be your strengths?_____
_____

What do you like most about yourself?_____
_____

How do you typically cope with problems in your life? _____
_____

What have you already found to be helpful/not helpful with your current concern? _____
_____
_____

Is there anything else you want me to know? _____
_____
_____

Client Signature _____ Date _____