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INITIAL INTERVIEW

All of the Information Given on this Form is Encryption Protected and HIPAA compliant

Date: _____

Name: _____ Female _____ Male _____
First Middle Last

Home Address: _____
Street and Number Apt. # City and State Zip Code

Phone: ( ) _____ Is it ok to leave a voice message here? Yes _____ No _____

Email: _____

Age: _____ Date of Birth: _____/_____/_____ Place of Birth: _____

Relationship Status: (Check one)

Single _____ Married _____ Domestic Partnership _____ Separated _____ Divorced _____ Widowed _____

If married, how long? _____ If Living Together, how long? _____

If separated how long? _____ If divorced, how long? _____ If widowed, how long? _____

Please list names and ages of your children, if any:

_____ _____ _____ _____

Please list names and ages of all people currently living with you, as well as your relationship to them:

_____ _____ _____ _____

Have you been in therapy before? (Check one) Yes _____ No _____ When: _____

Have you experienced any life changes or stressful events recently? If so, please explain: _____

_____

_____

Please describe in your own words the issues that brought you here: _____

_____

_____

Do you have a goal you hope to achieve in therapy? If so, what is it? _____

_____

_____

Are you currently experiencing anxiety, panic attacks, or any phobias? (Check one) Yes _____ No _____

If yes, when did you begin to experience this? _____

Are you currently experiencing sadness, grief, or depression? (Check one) Yes _____ No _____

If yes, when did you begin to experience this? _____

_____

Have you ever contemplated or attempted suicide? ("Check one) Yes _____ No _____ If so, when:

_____

Has anyone in your family committed or attempted suicide? ("Check one) Yes _____ No _____

If so, who and when: _____

Have you ever experienced physical abuse? _____ sexual abuse _____ emotional abuse _____ (Check all that apply)

If yes, when and by who: _____

Have you ever had a physical fight with your husband/wife/partner/anyone else? (I.e. shoving, throwing objects, hitting?)
Yes _____ No _____ (Check one)

Have you ever been convicted of a crime? Yes _____ No _____ (Check one)

What do you consider to be your personal strengths? _____

_____

What do you consider to be your personal weaknesses? _____

_____

Are you employed? (Check one) Yes _____ No _____

What is your occupation? _____

Would you like to list an emergency contact? If yes, please do so with contact information.

_____

What is your relationship to this person? _____

<u>YOUR GENERAL HEALTH INFORMATION</u>:

Do you have a primary care physician? (Check one) Yes _____ No _____

How would you rate your current physical health? (Check one)

Poor _____ Unsatisfactory _____ Satisfactory _____ Good _____ Very Good _____

How would you rate your current sleeping habits? (Check one)

Poor _____ Unsatisfactory _____ Satisfactory _____ Good _____ Very Good _____

Please list any health problems you are currently experiencing: _____

_____

Please list any difficulties you experience with your appetite or eating patterns? _____

_____

How many times per week do you generally exercise? _____

Are you currently experiencing any physical pain? (Check one) Yes _____ No _____

Has a physician or psychiatrist ever prescribed medication for difficulties such as depression, anxiety, or other?

(Check one) Yes _____ No _____

If yes, please identify them and provide approximate dates:

Name of Medication: _____ **Approximate Dates Taken:** _____
From - To

_____ _____
From - To

If more, list here: _____

How often do you engage in recreational drug use? (Check one)

Daily _____ Weekly _____ Monthly _____ Infrequently _____ Never _____

If yes, please identify what:

_____ _____ _____ _____

Do you drink alcohol? _____ Yes _____ No (Check one)

If yes, what: _____ **How much:** _____ **How often:** _____

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

	Please Check "Yes" or "No"		*List Family Member (mother, brother, etc.)*
Alcohol/Substance Abuse:	**Yes _____**	**No _____**	_____
Anxiety:	**Yes _____**	**No _____**	_____
Depression:	**Yes _____**	**No _____**	_____
Domestic Violence:	**Yes _____**	**No _____**	_____
Emotional Abuse/Neglect:	**Yes _____**	**No _____**	_____
Sexual Abuse:	**Yes _____**	**No _____**	_____
Eating Disorders:	**Yes _____**	**No _____**	_____
Obesity:	**Yes _____**	**No _____**	_____
Impulsive Behavior:	**Yes _____**	**No _____**	_____
Suicide (or Suicide Attempts):	**Yes _____**	**No _____**	_____
Schizophrenia:	**Yes _____**	**No _____**	_____
Other: (If so, explain)	**Yes _____**	**No _____**	_____

Thank you!

How did you learn about me?

Referral ____ Website ____ Yelp ____ PsychologyToday ____ Social Media ____ Google ____ Other ____