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<u>All of the Information Given on this Form is Protected and Confidential</u>

Date: ____________________

Name: ____ Female ____ Male ____
First Middle Last

Name of Parent/Guardian (if under 18 years of age):

____

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

Home Phone: ( ) _______________ Is it ok to leave a voice message here? Yes No
(Please circle one)

Cell Phone: ( ) _______________ Is it ok to leave a voice message here? Yes No
(Please circle one)

Work Phone: ( ) _______________ Is it ok to leave a voice message here? Yes No
(Please circle one)

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

____

____

(Please turn over)

If you are employed, what is your current employment situation?

____

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

____

What is your relationship to this person? ____

Have you ever been in therapy before? _____ Yes _____ No (check one)

If so, when and for how long? ____

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? __________________________

____

____

What do you consider to be your personal strengths? _______________________________________

____

What do you consider to be your personal weaknesses? _____________________________________

____

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

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

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

If yes, when did you begin experiencing this? ____

Have you ever experienced physical abuse ______ sexual abuse ______ emotional abuse ______?
(If yes, please check)

If yes, when? ____

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

Have you ever been arrested for a crime? _____ Yes _____ No (check one)

Have you even been convicted of a crime? _____ Yes _____ No (check one)

Have you ever contemplated or attempted suicide? _____ Yes _____ No (check one)

Has anyone in your family ever contemplated or attempted suicide? _____ Yes ____ No (check one)

If yes, please identify the family member: ____

GENERAL HEALTH INFORMATION:

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

How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very Good

How would you rate your current sleeping habits? (Please circle)

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? ____________________________________

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

_____ Yes _____ No (check one)

If yes, please identify them and provide approximate dates:

_________________________ _________________________ _________________________

How often do you engage in recreational drug use?

Daily _____ Weekly _____ Monthly _____ Infrequently _____ Never _____ (check one)

If yes, please identify:

_________________________ _________________________ _________________________

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

If yes, what, how much, and how often? ____

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

(Please Turn Over)

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 (father, grandmother, uncle, etc.)

Please Circle and List Family Member

Alcohol/Substance Abuse	Yes	No	
Anxiety	Yes	No	
Depression	Yes	No	
Domestic Violence	Yes	No	
Sexual Abuse	Yes	No	
Emotional Abuse/Neglect	Yes	No	
Eating Disorders	Yes	No	
Obesity	Yes	No	
Suicide Attempts	Yes	No	
Impulsive Behavior	Yes	No	
Schizophrenia	Yes	No	

How did you learn about me? (If referred, by whom?) ____

CLIENT AVAILABILITY FOR WEEKLY APPOINTMENTS

Please list all days and hours that you can be available for therapy so that we can work out a time to schedule you regularly:

Comments related to availability: ____

____

____

Thank you!