The following questions are designed to help me best meet your treatment needs. If the person seeking care is a minor, the parent or guardian should complete the form. If you have any questions, I am happy to answer them.

Name: ____ Date: __________

Name of parent/guardian (if under 18) ________________________________

Address: ____

City, State, Zip: ____

Phone: ______________________ Other phone: ____________________

DOB: __________ Age: ______ Sex: ________ Marital Status:_____

Email: ______________________

Employer: _______________________ Position: ___________________

Education: ____

Is client a student? Full-time or Part-time Name of School**:** ______________

Please list any children/age: ____

Referred by: ____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

Have you previously received any type of mental health services(psychotherapy, psychiatric, etc.,)?
No Yes

Yes, previous therapist/practitioner: ____________________________________

List any substance abuse treatment of inpatient treatment you have had, and the dates:

____

Are you currently taking any prescription medication or supplements? No Yes

Please list: ____

____

Please list any health problems you are currently experiencing:

____

Please list any sleeping problems you are currently experiencing? ________________________

____

How many times per week do you exercise? ____

Please list any difficulties you experience with your appetite or eating patterns: ________

____

Are you currently experiencing sadness, grief or depression? ___ Yes ____ No

If yes, for approximately how long?

____

Are you currently experiencing anxiety, panic attacks or have any phobias? ___ Yes ____ No

If yes, when did you begin experiencing this? ____________________________________

Do you experience any problems with focus, inattention? Yes No

If yes, please describe: ____

Are you currently experiencing chronic pain? ____ Yes ____ No

If yes, please describe ____

Do you drink alcohol more than once a week? No Yes

How often do you engage in recreational drug use? Daily Weekly Monthly Infrequently Never

Are you currently in a romantic relationship? No Yes

If yes, for how long? _______On a scale of 1-10, how would you rate your relationship? ________

Do you have a network of friends or social support? Yes No

What significant life changes or stressful events have you experienced recently?

____

Please indicate if you are having any of the following problems, or if you had them in the past:

	Current	Past
Difficulty falling asleep or staying asleep	________	_______
Sleeping too much	________	_______
Change in appetite, weight loss, or weight gain	________	_______
Frequent Crying	________	_______
Panic attacks or anxiety attacks	________	_______

Thoughts of killing or hurting myself	________	________
Attempts to kill or hurt myself	________	________
Problems Concentrating	________	________
Problems Remembering things	________	________
Periods of daily sadness lasting more than 2 weeks	________	________
I startle easily	________	________
Can't stop remembering upsetting events	________	________
Difficulty controlling my temper	________	________
I physically hurt other people	________	________
I break things sometimes	________	________
I worry a lot	________	________
Little or no interest in sex	________	________
I feel tired almost every day	________	________
Made myself throw up in order to lose weight	________	________
Used laxatives or exercised excessively to lose weight	________	________
I often feel like I am an outsider	________	________
Worry that something is wrong with my body	________	________
Frequent arguments with the people I live with	________	________
Other (please list)		

FAMILY HEALTH HISTORY:

If there is a family history of any of the following, please circle yes or no. If yes, please indicate the family member's relationship to you in the space provided.

	Please Circle	Family Member
Alcohol/Substance abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Disorder	yes/No	
Schizophrenia	yes/no	
Suicide attempts	yes/no	