



Patient Information:

Name (Full): _____ Date: _____

Today's Date: ____/____/____

Date of Birth: ____/____/____ Age: _____ Identified Sex: _____

Physical/Mailing Address: _____ Apt. _____

City: _____ State: _____ Zip: _____

Phone: Preferred _____ Alternate: _____ Work: _____

E-mail: _____

Is it okay to send email to this address? Yes No

What is your ethnic identity? _____ Religious preference: _____

Employer: _____ Occupation: _____

Employer Address: _____ Telephone: () _____ - _____

What is the highest grade of school you completed?

If you are a student, where do you attend school?

Which of the following applies to you?

I am ___ Single ___ Married ___ Partnered ___ Divorced ___ Widowed ___ Other

If you are with your partner now, what is your partner's name? _____

Please list the names and ages of your children. Please note if they are biological, adopted, step, or foster.

Emergency contact

Name: _____ Relationship to you _____

Address: _____

Phone Daytime: _____ Evening: _____ Cell/Alt: _____

REFERRED BY:

Statement of Need:

Please state in detail your present issues, how long they have persisted, and your reason for seeking treatment at this time (use as much space as you like. Feel free to write on back of this page).

Please circle or underline any of the following that pertain to you:

| | | | |
|-----------------|------------------------|-------------------|-----------------------|
| Anxiety | Suicidal Thoughts | Career Choices | Spirituality Concerns |
| Sexual Concerns | Drug/Alcohol Use | Sleep Changes | Life Transitions |
| Finances | Feelings of Insecurity | Cutting/Self-Harm | Grief and Loss |
| Self-Control | Abuse | Trauma | Disordered Eating |
| Work-Stress | Worry/Fear | Relationships | Health Concerns |
| Depression | Separation/Divorce | Anger | Other _____ |

Have you previously received mental health services? Yes No
(Psychotherapy, psychiatric care, drug or alcohol treatment etc.)

If yes, please provide provider's name: _____

Reason you sought services: _____

What was most helpful? _____

What was least helpful? _____

Have you had past psychiatric hospitalizations? Yes No

If yes, please state where and reason for hospitalization: _____

Have you ever attempted or considered suicide? Yes No

If yes please provide some detail: _____

Do you currently feel suicidal, or do you currently experience unwanted thoughts of wanting to end your life? Yes No

If yes, please provide some detail: _____

List any major physical illness, hospitalizations, accidents that you have had and at what age they occurred: _____

What medications do you take? (include non-prescription, herbal medicines and supplements)

| Medicine | Dose | Frequency | Who prescribes |
|----------|-------|-----------|----------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Please list any allergies, including medication allergies/sensitivities:

What recreational substances do you use / have you used in past, if any (please include alcohol and cigarettes)?

How often do you use these substances (if not currently using, how often in past)?

Do you consider any of your substance use to be a problem? _____ Yes _____ No
If yes, please describe:

Are you having any problems with your sleep habits? _____ Yes _____ No
(If yes, circle where applicable)

Sleeping too little Sleeping too much Poor sleep Disturbing dreams Other

Use this space to describe sleep issues:

How many times a week do you exercise? _____ For about how long each time? _____

What type of exercise do you do? _____

Are you having any difficulty with appetite or eating habits? _____ Yes _____ No
(If yes, circle where applicable)

Eating less Eating more Binging Restricting Significant weight change

Do you have any problems or worries about sexual functioning? _____ Yes _____ No
(If yes, circle where applicable)

Lack of desire Performance Problem Sexual Impulsiveness Arousal Difficulties Other

What activities do you enjoy doing in your free time?

Family Background Questionnaire

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:

| | | | List Family Member Relationship |
|-------------------------------|-----|----|---------------------------------|
| Alcohol/Substance Abuse | Yes | No | _____ |
| Anxiety | Yes | No | _____ |
| Depression | Yes | No | _____ |
| Domestic Violence | Yes | No | _____ |
| Obsessive Compulsive Disorder | Yes | No | _____ |
| Psychiatric Hospitalizations | Yes | No | _____ |
| Suicide Attempts/Completion | Yes | No | _____ |
| Weight/Eating Disorders | Yes | No | _____ |

How much is your immediate family a source of emotional support for you? (Circle one):

None Little Somewhat Substantial Very Strong

Besides family members who do you count on right now for friendship or emotional support?
Please name and note relationship

Additional Information:

What do you consider to be some of your strengths?

What do you consider to be some of your weaknesses?

What would you like to accomplish out of your time in therapy?

Any other information you like me to know?

Client Signature: _____

Date: _____

Clinician Signature: _____

Date: _____