Ruth Graham, MA LMHC
Child, Adolescent, Adult & Family Therapist
DBA Hope Counseling Centers

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 is 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:____________________