

**Please fill in the information below and bring it with you to your first session.**

Information provided on this form is protected as confidential information.

**Personal Information**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ May we leave a message? ☐ Yes ☐ No

Email: \_\_\_\_\_ May we leave a message? ☐ Yes ☐ No

**\*Please note:** Email correspondence is not considered to be a confidential medium of communication.

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

**Significant Other:** \_\_\_\_\_

Cell/Work/Other Phone: \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_

Cell/Work/Other Phone: \_\_\_\_\_

Referred By (if any): \_\_\_\_\_

**History**

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? ☐ No ☐ Yes, previous therapist/practitioner: \_\_\_\_\_

Are you currently taking any prescription medication? ☐ Yes ☐ No

**If yes,** please list with doctor's name (s):

Medication

Prescribing MD: Primary MD/PCP

Have you ever been prescribed psychiatric medication? ☐ Yes ☐ No

**If yes,** please list and provide dates with doctor's name (s):

Medication

Dates

Prescribing MD:

**General and Mental Health Information**

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

Poor   Unsatisfactory   Satisfactory   Good   Very good

Please list any specific health problems you are currently experiencing:

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

Poor   Unsatisfactory   Satisfactory   Good   Very good

Please list any specific sleep problems you are currently experiencing:

3.      How many times per week do you generally exercise? \_\_\_\_\_ What types of exercise do you participate in?

4.      Please list any difficulties you experience with your appetite or eating problems:

5.      Are you currently experiencing overwhelming sadness, grief or depression? ☐ No ☐ Yes  
If yes, for approximately how long?

6.      Are you currently experiencing anxiety, panics attacks or have any phobias? ☐ No ☐ Yes  
If yes, when did you begin experiencing this?

Are you currently experiencing any chronic pain?    ☐ No ☐ Yes

If yes, please describe:

7.      Do you drink alcohol more than once a week?            ☐ No ☐ Yes  
How many ounces per day/night

8.      How often do you engage in recreational drug use? Including THC  
How much daily use do you use: \_\_\_\_\_ Do you feel as if you are chemically dependent?  
☐ Daily   ☐ Weekly   ☐ Monthly   ☐ Infrequently   ☐ Never

9.      Are you currently in a romantic relationship? ☐ No ☐ Yes If yes, for how long?  
On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?

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

## 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 (e.g. father, grandmother, uncle, etc.)

|                               | Please Circle | List 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 Behavior | yes / no      |                    |
| Schizophrenia                 | yes / no      |                    |
| Suicide Attempts              | yes / no      |                    |

## Additional Information

1. Are you currently employed? ☐ No ☐ Yes

If yes, what is your current employment situation?

Do you enjoy your work? Is there anything stressful about your current work?

Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes

If yes, describe your faith or belief:

2. What do you consider to be some of your strengths?

3. What do you consider to be some of your weaknesses

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