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GENERAL

Date: _____ Full Name: _____

Home Address: _____

Phone (Please check preferred number)

☐ Work: _____ ☐ Home: _____ ☐ Cell: _____

Is it ok to leave a confidential messages on the above phone number(s)? Y N

Age: _____ Date of Birth: _____ Marital/Relationship Status: _____

Name & Ages of Children: _____

_____

Occupation: _____

Emergency Contact Information: _____

Who referred you to me? _____

FAMILY OF ORIGIN HISTORY

Mother's Name: _____ Still living? _____ If not, year deceased: _____

Father's Name: _____ Still living? _____ If not, year deceased: _____

Names and Ages of Siblings: _____

_____

AREAS OF CONCERN

What brings you to therapy at this time? _____

_____

_____

_____

Do you have any specific goals with regard to therapy?

Do you have any particular concerns/fears with regard to therapy?

PSYCHOLOGICAL HISTORY

Have you ever received psychotherapy before?

When and for how long?

What was the focus of treatment?

Where did you receive treatment?

Have you ever been hospitalized for emotional reasons?

When? For how long?

Why were you hospitalized?

Where were you hospitalized?

Are you currently taking any prescription medications?

Prescribed by whom?

What are the medications (continue on back if you need more space)?

Medication	For which symptoms	Dosage	For how long?
Medication	For which symptoms	Dosage	For how long?
Medication	For which symptoms	Dosage	For how long?

Have you ever attempted suicide? _____ When? _____

Describe the circumstances that led to that attempt: _____

_____

_____

Are you currently having any suicidal thoughts? Please describe: _____

_____

Have you ever been subjected to verbal, physical, emotional or sexual abuse? Please describe:

_____

_____

Have you ever been the victim of a violent crime? Please describe: _____

_____

MEDICAL HISTORY

Have you ever been diagnosed with a serious illness? Please describe: _____

_____

Do you have any medical conditions that may affect your mental health treatment? _____

_____

Please describe your overall health today: _____

Are you physically active? Please describe: _____

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related conditions? Please describe:

_____

_____

Are you now or have you ever been in a 12-step program? Please describe: _____

_____

Do you smoke tobacco? [Y] [N] How much? _____ For how long? _____

Do you smoke marijuana? [Y] [N] How much? _____ For how long? _____

Do you drink alcohol? [Y] [N] On average, how many drinks do you consume per week? _____

Do you take any prescription medications that have not been prescribed to you? Y N

Please describe your use: _____

_____

Do you currently use illegal drugs? Y N Have you ever used illegal drugs? Y N

Please describe your use: _____

_____

OTHER INFORMATION

Please describe your spiritual identity/orientation: _____

Please describe your interests/hobbies: _____

Are you now or have you ever been involved in a lawsuit? _____

What were the circumstances around the lawsuit? _____

Please feel free to include any other information you feel would be helpful to your treatment: