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Please complete the following form, leaving blank any items that you do not feel comfortable answering.

Name: _____ Date: ____ / ____ / ____ Date of Birth: ____ / ____ / ____

Preferred pronouns: _____

Address: _____ City _____ State _____ Zip _____

Preferred Phone: _____ □ Home □ Cell □ Other

May I contact you/leave a message at this number? □ Yes □ No

Email: _____

May I contact you at this email address? □ Yes □ No

_ _

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Emergency Contact Phone Number: _____ □ Home □ Cell □ Other _____

LOCAL EMERGENCY CONTACT

Check if same as above □

Name: _____ Relationship: _____

Emergency Contact Phone Number: _____ □ Home □ Cell □ Other _____

_ _

RELATIONSHIP CONCERNS

Referred to therapy by: _____

Please check your current marital status:

□ Engaged □ Married □ Divorced □ Separated □ Widowed □ Partnership

□ Domestic Partnership □ Involved with Multiple Partners □ Other_____

How long have you been in a relationship? _____

Please list any children and their ages:_____

Please describe your primary relationship concern:_____

_____

_____

_____

How long have you had this challenge?_____

Please indicate your current level of happiness in your relationship by circling a number from 1 - 10:

Extremely unhappy		Unhappy		Fairly unhappy	Happy		Fairly happy	Extremely happy		Perfect
1	2	3	4	5	6	7	8	9	10	

As you think about the primary reason that brings you here, what is your current overall level of concern?

_____No Concern _____Little Concern _____Moderate Concern _____Serious Concern

Please indicate your current living situation

□ Live alone □ Live with parents or other family members

□ Live with spouse or partner □Live with roommate(s) □ Other: _____

Please elaborate on any sexual concerns_____

_____

How satisfied are you with the **frequency** of your sexual relationship?

□ far too often to suit me □ a bit too often to suit me □ about right

□ a bit seldom to suit me □ far too seldom to suit me

Have you ever been separated as a couple? □ Yes □ No

If so, when? _____

How long did the separation last?_____

Have either you or your partner struck, physically restrained, used violence against or injured the other person?

□ Yes □ No

If yes, please elaborate _____

_____

———

DEMOGRAPHIC INFORMATION

What is your age? _____

How do you identify your gender? _____

How do you identify your race? _____

How do you identify your ethnicity or heritage? _____

How do you identify your sexual orientation? _____

How would you identify your relationship status? _____

What is your education level? _____

Are you a student (if Y, school/year) _____

What is your employment status? _____

What is your current occupation? _____

Have you been in the military (if Y, where/when)? _____

If you were raised in a particular religious/spiritual tradition, please identify:_____

How would you identify yourself today? _____

———

PREVIOUS MENTAL HEALTH TREATMENT

Have you previously received any mental health services (psychiatry, psychotherapy, group therapy etc.)?

□ Yes □ No

If yes, When:_____

How long:_____

With whom:_____

For what:_____

What did you find helpful or unhelpful about your previous therapy experience:_____

_____

Have you ever been hospitalized for psychiatric reasons? □ Yes □ No

If yes, please elaborate (reason, duration, location, date):_____

_____

Have you ever engaged in self-injurious behavior (i.e., cutting, burning, skin picking, hair pulling etc.)?

□ Yes □ No

If yes, please elaborate:_____

_____

Have you seriously considered attempting suicide in the past? □ Yes □ No

If yes, please elaborate: _____

_____

Have you attempted suicide in the past? □ Yes □ No

If yes, please elaborate:

_____

_____

MEDICAL HISTORY

Do you have a primary care physician? □ Yes □ No

If yes, name: ____ Date of last exam: _____ / _____ / _____

Please list any medical conditions that you have: ____

____

Please list any medical/health concerns that you have: ____

____

Please list any *Over-The-Counter* medication you are currently taking:

Name: Dose: Frequency Reason

____

____

Please list any *Prescribed* medication you are currently taking:

Name: Dose: Frequency Reason

____

____

Please list the name and contact information of your prescribing psychiatrist:

Name: ____

Phone Number: ____

Date of last visit: ____/_____/_____

Please list any disabilities that you have: ____

____

SUBSTANCE USE

Please check all that apply:

Alcohol □ If so, how much/how often: ____

Cocaine □ If so, how much/how often: ____

Heroin ☐ If so, how much/how often: ______________________________

Ecstasy ☐ If so, how much/how often: ______________________________

Marijuana ☐ If so, how much/how often: ______________________________

PCP ☐ If so, how much/how often: ______________________________

LSD ☐ If so, how much/how often: ______________________________

Pills ☐ If so, what/how much/how often: ______________________________

Other ☐ If so, what/how much/how often: ______________________________

Have you ever been in a substance abuse treatment program?: ☐ Yes ☐ No

If yes, Name(s): ______________________________

Date(s): ______________________________

Duration: ______________________________

FAMILY HISTORY

Please described the relationship status of your parents/guardians: ______________________________

____

Please list any siblings and their ages:______________________________

____

Please mark each as yes or no. If yes, please indicate the family member affected

Depression	☐ Yes	☐ No	____________
Anxiety Disorder	☐ Yes	☐ No	____________
Bipolar Disorder	☐ Yes	☐ No	____________
Panic Attacks	☐ Yes	☐ No	____________
Obsessive Compulsive Behavior	☐ Yes	☐ No	____________
Alcohol/Substance Abuse	☐ Yes	☐ No	____________
Eating Disorder	☐ Yes	☐ No	____________
Learning Difference	☐ Yes	☐ No	____________
Trauma History	☐ Yes	☐ No	____________
Domestic Violence	☐ Yes	☐ No	____________
Obesity	☐ Yes	☐ No	____________

Schizophrenia □ Yes □ No _____

Other □ Yes □ No _____

Do you have a history of (please mark all that apply):

□ Physical Abuse □ Neglect □ Other traumatic experience:_____

□Emotional Abuse □Sexual Abuse/Assault

PRESENTING CONCERNS AND SYMPTOMS

Use the scale below to indicate the degree to which each area is of concern for you. Circle a number for each item.

	Minimal Concern	**Significant Concern**
Sadness and depression:	0----------1----------2----------3----------4----------5	
Grief and loss:	0----------1----------2----------3----------4----------5	
Nervousness and anxiety:	0----------1----------2----------3----------4----------5	
Obsessive behaviors:	0----------1----------2----------3----------4----------5	
Feelings of stress:	0----------1----------2----------3----------4----------5	
Feelings of frustration:	0----------1----------2----------3----------4----------5	
Inconsistencies in mood:	0----------1----------2----------3----------4----------5	
Thoughts of self-harm:	0----------1----------2----------3----------4----------5	
Thoughts of harming others:	0----------1----------2----------3----------4----------5	
Health concerns:	0----------1----------2----------3----------4----------5	
Sexual concerns:	0----------1----------2----------3----------4----------5	
Difficulty sleeping:	0----------1----------2----------3----------4----------5	
Eating concerns:	0----------1----------2----------3----------4----------5	
Body image:	0----------1----------2----------3----------4----------5	
Substance and/or alcohol use:	0----------1----------2----------3----------4----------5	
Traumatic experience(s):	0----------1----------2----------3----------4----------5	
Sexual orientation:	0----------1----------2----------3----------4----------5	
Spirituality:	0----------1----------2----------3----------4----------5	
Family Relationships:	0----------1----------2----------3----------4----------5	

Social Relationships:	0----------1----------2----------3----------4----------5
Romantic Relationships:	0----------1----------2----------3----------4----------5
Work:	0----------1----------2----------3----------4----------5
School:	0----------1----------2----------3----------4----------5
Financial issues:	0----------1----------2----------3----------4----------5
Legal issues:	0----------1----------2----------3----------4----------5
Other: _____	0----------1----------2----------3----------4----------5

Please list any hobbies and/or activities you do for fun: _____

_____

What are your greatest challenges? _____

_____

What would you name as your strengths? _____

_____

Signature: _____ Date: ____ / ____ / ____

I appreciate your openness in providing the above information and look forward to working with you.