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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 _____

REFERRAL REASON

Referred to therapy by: _____

Describe your primary reason for seeking therapy at this time. (What significant life changes or stressful events have you experienced recently?) _____

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 Domestic Violence

Please check your current marital status:

- Single Engaged Married Divorced Separated Widowed
- Domestic Partnership Involved with Multiple Partners Other _____

Please list any children and their ages: _____

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: _____

Are you currently in a romantic relationship? Yes No

If yes, please describe how long and any concerns: _____

Please describe any sexual concerns you may have? _____

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.