PATIENT INFORMATION

Patient's name:_____ Today's date:___/___/_____

Address:_____
(Street) (City) (State) (Zip)

Date of birth: ___/___/_____ Gender: _____ Sexual orientation: _____

To which cultural/ethnic group(s) do you belong: _____

Occupation: _____ Employer (if applicable): _____

Home Phone: _____ Mobile Phone: _____

Email: _____

CONTACT INFORMATION

OK to email? ☐ Yes ☐ No
What is the preferred email address? ___
OK to call? ☐ Yes ☐ No
OK to leave message? ☐ Yes ☐ No
What is the preferred number? _____

Please provide a name and phone number of whom to call in case of an emergency: _____

_____

REFERRAL INFORMATION

Who referred you to me or how did you hear of my practice? _____
May I have your permission to contact this person to thank him or her for the referral?

☐ Yes ☐ No

Current reason(s) for seeking therapy: _____
_____
_____
_____
_____
_____
_____
_____
_____

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Please estimate the degree of difficulty experienced in each area by marking each item with the appropriate number: 1 = no difficulty 2 = mild difficulty
3 = moderate difficulty 4 = severe difficulty 5 = very severe

___ Job/school
___ Family relationships
___ Friendships
___ Partner/relationship
___ Food/body image
___ Violence/abuse/trauma
___ Alcohol/drug use
___ Medical condition
___ Life transition(s)
___ Grief/loss
___ Sexual identity
___ Other, specify: _____

Seeking counseling to help with (check all that apply):

☐ Coping ☐ Eating disorder ☐ Sexual concerns
☐ Anxiety ☐ Sleeping problems ☐ Career concerns
☐ Depression ☐ Addictive behaviors ☐ Family Conflict
☐ Fear/phobias ☐ Existential concerns ☐ Problem in Relationship
☐ Other, specify: _____

I have had an unwanted sexual experience:

☐ never ☐ recently ☐ in the past ☐ unsure

I consider my unwanted sexual experience to be:

☐ rape ☐ incest ☐ sexual assault ☐ other

I am dissatisfied with my personal appearance: ☐ Yes ☐ No

I have tried to control my weight: ☐ recently ☐ in the past

With: ☐ vomiting ☐ laxatives ☐ diuretics
☐ excessive exercise ☐ diet pill ☐ no eating/dieting

FAMILY INFORMATION

Who currently lives with you in your home or is a part of your immediate family?

Name	Age	Relationship (i.e., parent, spouse, partner, child, pet, etc.)

Is your mother still living? ☐ Yes ☐ No
Is your father still living? ☐ Yes ☐ No

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Are your parents (check all that apply): ☐ Married to each other ☐ Divorced/separated ☐ Remarried ☐ Never married

Special circumstances (e.g., raised by person other than parent(s), information about spouse/children not living with you, etc.): _____

Is there any alcohol or drug abuse in your current home that concerns you?
☐ Yes ☐ No ☐ Unsure
Is there any violence or other abuse in your current home that concerns you?
☐ Yes ☐ No ☐ Unsure

Was there any alcohol or drug abuse in your home growing up? ☐ Yes ☐ No ☐ Unsure

Was there any violence or physical abuse in your home growing up? ☐ Yes ☐ No ☐ Unsure

Was there any violence or sexual abuse in your home growing up? ☐ Yes ☐ No ☐ Unsure

Was there any verbal abuse in your home growing up? ☐ Yes ☐ No ☐ Unsure

Other childhood circumstances (such as neglect or inadequate nutrition, trauma, frequent moves, parent death, etc.) that affected your development? _____

_____

How would you describe your relationship with your mother?
☐ Good ☐ Fair ☐ Poor ☐ Non-existent
How would you describe your relationship with your father?
☐ Good ☐ Fair ☐ Poor ☐ Non-existent

Relationship status (more than one answer may apply):

Assessment of current relationship (if applicable): ☐ Good ☐ Fair ☐ Poor

☐ Single

Total # of marriages: ___

☐ Legally married (for # ___ yrs.)

☐ Unmarried, living together (for # ___ yrs.)

☐ Divorced (length of time: ___ yrs.)

☐ Divorce in process (length of time: ___ yrs.)

☐ Annulment: (length of time: ___ yrs.)

☐ Widowed: (length of time: ___ yrs.)

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SOCIAL INFORMATION

How easy it is for you to make friends?

☐ very difficult ☐ somewhat difficult ☐ fairly easy ☐ very easy

How supportive/trustworthy do you feel your friends are?

☐ very ☐ somewhat ☐ a little ☐ not at all

Check how you generally get along with other people: (check all that apply)

☐ affectionate ☐ aggressive ☐ avoidant ☐ fight/argue often ☐ follower

☐ friendly ☐ leader ☐ outgoing ☐ shy/withdrawn ☐ submissive

☐ other (specify): _____

What do you wish were different about your friendships? _____

SPIRITUAL/RELIGIOUS

How important to you are spiritual matters?

☐ not ☐ little ☐ moderate ☐ very much

Are you affiliated with a spiritual or religious group? _____ If yes, what? _____

Were you raised within a spiritual or religious group? _____ If yes, what? _____

HEALTH INFORMATION

Name of your medical doctor: _____

Address of medical provider: _____ Phone: _____

Name of your psychiatrist/prescriber: _____

Address of psychiatrist/prescriber: _____ Phone: _____

Have you ever been hospitalized? (If yes, please provide details): _____

Are you currently taking any prescribed medications?

Names	Dosage	Frequency	Prescriber

Have you experienced any significant health or physical changes in the past year? _____

Please list any current health concerns: _____

Have you been diagnosed with a learning disability, identified as gifted, or other special circumstances? ____

Have you previously participated in psychotherapy? If yes, please fill out the info below:

Therapist Name	Location (City/State)	Dates

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Was it helpful? (Why or why not?) _____

_____

Have you ever had thoughts of wanting to end your life? ☐ Yes ☐ No

If yes, when? _____

Have you ever had a plan as to how, when, or where you might end your life? ☐ Yes ☐ No

If yes, when? _____

Do you have any previous suicide attempts, self-destructive behaviors, or violent behaviors?

☐ Yes ☐ No

When did you have these? (Indicate age, circumstances, and whether it led to hospitalization or legal problems) _____

_____

Have you ever thought about seriously harming another person? ☐ Yes ☐ No

If yes, when? _____

Have you ever attempted to physically harm someone? ☐ Yes ☐ No

If yes, when? _____

Please list any past drug and alcohol use. What have you used and how much? _____

_____

The following has resulted from my use of alcohol/drugs:

☐ traffic ticket/violation ☐ ruined relationship ☐ black outs ☐ fight with friend

☐ problems with school/job ☐ difficulties with memory

What are you currently using and how much? _____

What is the frequency of use? ☐ less than once per month ☐ monthly

☐ several times per week ☐ weekly

Have any family members been diagnosed and/or treated for mental or emotional conditions?

☐ Yes ☐ No ☐ Unsure If yes, please explain: _____

_____

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PATIENT INFORMATION

OTHER

What do you consider your main strengths?

What special areas of interest, activities or hobbies do you enjoy?

How often do you participate in/do the above now vs. in the past?

What are your primary challenges right now?

What are your most important hopes or dreams?

Please add any additional information that may be helpful to our work together.

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