Please print out this form and bring it to your first session or allow yourself thirty minutes prior to your appointment to complete the form in the office. All information provided is confidential and will remain in your client file.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if you are a minor): _____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status:
□ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Have you ever been previously married? □ Yes □ No

Number of Children: _____ Ages of children: _____

Are you currently receiving therapeutic services, professional counseling or psychotherapy elsewhere?
□ Yes □ No

Have you had previous psychotherapy?
□No □Yes, at Previous therapist's name _____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
□Yes □No If Yes, please list: _____

If no, have you been previously prescribed psychiatric medication?
□Yes □No If Yes, please list: _____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle) *Poor Unsatisfactory Satisfactory Good Very good*

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

_____

_____

3. Are you having any problems with your sleep habits? □ No □ Yes

If yes, check where applicable:
□ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams
□ Other _____

4. How many times per week do you exercise? _____
Approximately how long each time? _____

5. Are you having any difficulty with appetite or eating habits? □ No □ Yes

If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting

Have you experienced significant weight change in the last 2 months? □ No □ Yes

6. Do you regularly use alcohol? □ No □ Yes

In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

7. How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Rarely
□ Never

8. Have you had suicidal thoughts recently? □ Frequently □ Sometimes □ Rarely □ Never

Have you had them in the past? □ Frequently □ Sometimes □ Rarely □ Never

9. Are you currently in a romantic relationship? □ No □ Yes
If yes, how long have you been in this relationship? _____
On a scale of 1-10, how would you rate the quality of your current relationship? _____

10. In the last year, have you experienced any significant life changes or stressors:
_____

11. Have you ever experienced any abuse? □ physical □emotional □sexual □ None
If yes, is the abuse currently ongoing? □ No □ Yes
What is your relationship with the abuser? _____
Are you currently in contact with this person? □ No □ Yes
When did the abuse occur? (date) _____

12. Have you ever experienced the loss of a close family member or friend? □ No □ Yes
If yes, who? _____
Date: _____

Have you ever experienced:

Extreme depressed mood: □ No □ Yes
Wild Mood Swings: □ No □ Yes
Rapid Speech: □ No □ Yes
Extreme Anxiety: □ No □ Yes
Panic Attacks: □ No □ Yes
Phobias: □ No □ Yes
Sleep Disturbances: □ No □ Yes

Hallucinations: □ No □ Yes
Unexplained losses of time: □ No □ Yes
Unexplained memory lapses: □ No □ Yes
Alcohol/Substance Abuse: □ No □ Yes
Frequent Body Complaints: □ No □ Yes
Eating Disorder: □ No □ Yes
Body Image Problems: □ No □ Yes
Repetitive Thoughts (e.g., Obsessions) : □ No □ Yes
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing) : □ No □ Yes
Homicidal Thoughts: □ No □ Yes
Suicide Attempt: □ No □ Yes
If yes, when?_____

OCCUPATIONAL INFORMATION:

Are you currently employed? □ No □ Yes

If yes, who is your current employer/position? _____

If yes, are you happy at your current position? _____

Please list any work-related stressors, if any: _____

EDUCATIONAL INFORMATION

Highest degree earned?

□ High School Diploma □ Bachelor's Degree □ Mater's Degree □ PhD

Degree in: _____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? □ No □ Yes

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? □ No □ Yes

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (check any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty	**Family Member**
Depression: □ No □ Yes	_____
Bipolar Disorder: □ No □ Yes	_____
Anxiety Disorders: □ No □ Yes	_____
Panic Attacks: □ No □ Yes	_____
Schizophrenia: □ No □ Yes	_____
Eating Disorders: □ No □ Yes	_____

Trauma History: □ No □ Yes _____
Suicide Attempts: □ No □ Yes _____
Learning Disabilities: □ No □ Yes _____
Alcohol/Substance Abuse: □ No □ Yes _____

OTHER INFORMATION:

What do you consider to be your strengths? _____
_____
_____

What do you like most about yourself? _____
_____
_____

What are effective coping strategies that you've learned? _____
_____
_____

How would you describe your reasons for seeking therapy?_____
_____
_____

What are your goals for therapy? _____
_____
_____