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Please fill in the information below and bring it with you to your first session. Information provided on this form is protected as confidential information.

Personal Information

Name: _____**D.O.B.**_____

Address: _____

Phone Number: _____**May we leave a message** □**Yes** □ **No**

Email: _____ **Age:** _____ **Gender:** _____

Marital Status: □ **Never Married** □ **Domestic Partnership** □ **Married**
□ **Separated** □ **Divorced** □ **Widowed**

Referred by (if any): _____

History

1. Have you previously received any type of mental health services (counseling, psychiatric services)?

□ **No** □ **Yes, previous therapist/ psychiatrist (please list below)**

1. Name: _____ **Year seen:** _____

2. Name: _____**Year seen:** _____

3. Name: _____ **Year seen:** _____

4. Name: _____**Year seen:** _____

2. Are you currently taking any prescription medications (including psychiatric): □ No □ Yes (please list below)

1._____How many times per day_____When: A.M./Afternoon/P.M.

2._____How many times per day_____When: A.M./Afternoon/P.M.

3._____How many times per day_____When: A.M./Afternoon/P.M.

4._____How many times per day_____When: A.M./Afternoon/P.M.

5._____How many times per day_____When: A.M./Afternoon/P.M.

6._____How many times per day_____When: A.M./Afternoon/P.M.

7._____How many times per day_____When: A.M./Afternoon/P.M.

8._____How many times per day_____When: A.M./Afternoon/P.M.

9._____How many times per day_____When: A.M./Afternoon/P.M.

10._____How many times per day_____When: A.M./Afternoon/P.M.

3. Have you ever been hospitalized due to a mental health concern: □ No □ Yes (please list below)

Place: _____ Date: _____

Place: _____ Date: _____

Reason: _____

_____

_____

General and Mental Health Information

1. How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any health problems you are currently experiencing (ex. chronic pain, diabetes, heart conditions, etc.): _____

_____

2. Have you had any surgeries/operations/procedures? □ No □ Yes (please list below)

1. _____ **date:** _____
2. _____ **date:** _____
3. _____ **date:** _____
4. _____ **date:** _____

3. How would you rate your current sleeping habits? (please circle one)

Poor Unsatisfactory Satisfactory Good Very Good

Please circle all that apply with regards to your current sleep:

□ sleeping to much □ not getting enough sleep □ having trouble falling asleep

□ having trouble staying asleep □ poor quality sleep

4. Do you currently exercise? □ No □ Yes

How often? _____ **What types of exercise?** _____

5. Do you currently or have you ever struggled with any eating issues? □ No □ Yes

Please check all that apply with regards to eating issues:

□ lack of appetite □ over eating □ binging/purging/bulimia □ anorexia □ trouble w/ swallowing

□ digestive issues □ acid reflux/ GERD □ other (please explain) _____

6. Are you currently experiencing grief due to a loss? □ No □ Yes

7. Do you drink caffeine? □ No □ Yes

Number of caffeinated beverages per day: _____ **Type of beverage:** _____

8. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

9. Is domestic abuse/violence present in your home or in previous homes? □ No □ Yes (please explain) _____

10. On a scale of 1-10 (with 1 being poor and 10 being exceptional) how would you rate your romantic relationship (if in one)?

1 2 3 4 5 6 7 8 9 10

11. Do you have any children or dependents living in the home with you? □ No □ Yes

Please list all who live in the home with you and your current relationship satisfaction with each

1. Name: _____ Age: _____ Satisfaction level: (1-10) _____

2. Name: _____ Age: _____ Satisfaction level: (1-10) _____

3. Name: _____ Age: _____ Satisfaction level: (1-10) _____

4. Name: _____ Age: _____ Satisfaction level: (1-10) _____

5. Name: _____ Age: _____ Satisfaction level: (1-10) _____

6. Name: _____ Age: _____ Satisfaction level: (1-10) _____

12. Please list any trauma or stressors you have experienced within your life (ex. abuse/ racism/ prejudice/ natural disasters/witnessing a death/ car accident/ war/ prison/etc.) _____

_____

_____

_____

13. Please list any current/ ongoing stressor (ex. death in the family/recent move/family stressors/ job change/ recent diagnosis/etc.) _____

_____

_____

_____

14. Do you currently use social media □ No □ Yes (please mark all that apply)

□Facebook □Instagram □Tiktok □Snapchat □Twitter □Other (Please list below)

_____

15. How many hours per day are you using social media? _____per/day

Family Mental Health History

In the section below please identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you (ex. mother, brother, grandmother, uncle).

ADHD: □ No □ Not sure □ Yes _____

Alcohol/Substance abuse: □ No □ Not sure □ Yes _____

Anxiety/Panic: □ No □ Not sure □ Yes _____

Bipolar Disorder: □ No □ Not sure □ Yes _____

Depression: □ No □ Not sure □ Yes _____

Domestic Violence: □ No □ Not sure □ Yes _____

Eating Disorders: □ No □ Not sure □ Yes _____

Neurodevelopmental Disorders: □ No □ Not sure □ Yes _____

Obsessive Compulsive Behaviors: □ No □ Not sure □ Yes _____

Personality Disorder: □ No □ Not sure □ Yes _____

PTSD/ Trauma: □ No □ Not sure □ Yes _____

Schizophrenia/Schizoaffective Disorder: □ No □ Not sure □ Yes _____

Suicide/Suicide attempts: □ No □ Not sure □ Yes _____

Additional Information

1. What is the highest level of education you have achieved? _____

2. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation (place/ full vs part time/ hours): _____

_____

3. On a scale of 1-10 (with 1 being poor and 10 being exceptional) how would you rate your employment satisfaction?

1 2 3 4 5 6 7 8 9 10

4. Is faith/spirituality/religion an important part of your life? □ No □ Yes

If yes, please describe your faith/spirituality/religion: _____

_____

_____

5. What do you consider to be some of your strengths? _____

_____

_____

6. What do you consider to be some of your weaknesses? _____

_____

_____

7. What are some things you would like to accomplish out of your time in therapy? _____

_____

_____

8. Is there any additional information your mental health provider should know? _____

_____

_____

_____

This document has been truthfully filled out by the best of my ability and knowledge:

Name: _____ **Signature:** _____