Please provide the following information below needed for our records. All information you provide is considered protected health information and will be held confidential as part of your medical record. If there are questions that you do not wish to answer at this time, feel free to leave them blank. Please bring the completed form with you to your first session.

Today's Date: ______/______/_________

____ ____________________________________ ________
(Client Last name) (First) (Initial)

Birth date: ______/______/_________ Age:______________ Sex: ❑ F ❑ M

Marital Status: ❑Never Married, ❑Married, ❑Divorced, ❑Separated, ❑Widowed, ❑Domestic Partnership

Please list children & ages ____

____

Local Address:____ _________________ _______ ___________
(Street & Number) (City) (State) (Zip Code)

Permanent Address: __________________________ ___________ _________________ _______ ___________
(If different than above)

Cell Phone: __________________________________May we leave a message? ❑Yes ❑No, Text? ❑Yes ❑No

Alternate Phone:_______________________________ ❑home ❑work, May we leave a message? ❑Yes ❑No

Responsible Party:________________________________ ___________________ __________________ ________
(Name) (Relationship) (Phone) (DOB)

Emergency contact:_________________________________ ___________________ _________________________
(Name) (Relationship) (Phone)

Referred by: ❑Medical Doctor, ❑Psychiatrist, ❑Therapist, ❑Family/Friend, ❑Self, ❑Job, ❑other_________________

I plan to use my insurance: ❑No, ❑Yes, enter below:

Insurance____
(Insurance name) (Member ID) (Group number)

Secondary Insurance____

Employment status: ❑Full-time ❑Part-time ❑Unemployed ❑Retired ❑Disabled ❑Student

Are you satisfied with your current employment status? ❑YES ❑NO ❑SOMETIMES

Employer____

Chief Concern (Please describe the main difficulty or reason that brings you to counseling at this time):

____

____

____

____

Please check any concerns and/or symptoms that you are experiencing:

❑Loss of interest in activities	❑Racing thoughts	❑Disorganized thoughts
❑Confusion	❑Overwhelming sadness	❑Significant change in energy level
❑Relationship concerns	❑Thoughts of suicide	❑Violent thoughts
❑Frequent crying	❑Thoughts of death and dying	❑Feeling hopeless
❑irritability or frustration	❑Anxiety or worry	❑Anger outbursts
❑Panic attacks	❑Self-harming behavior	❑Frequent physical complaints
❑Alcohol or drug use	❑Significant change in weight	❑Change in sexual activity
❑Sleep disturbance	❑Flashbacks	❑Distressing dreams
❑Specific fears	❑Fatigue	❑Feeling Worthless
❑Feeling helpless	❑Impulsiveness	❑Risky or reckless behavior
❑Difficulty concentrating	❑Recurring distressing thoughts	❑hypervigilant
❑Feeling on edge or keyed up	❑Restlessness	❑Muscle tension
❑Intrusive thoughts	❑Exaggerated startle response	❑Recent stressor or traumatic event
❑ Legal problems	❑Other:______________________	

Mental Health History

Have you ever received any mental health services? ❑None ❑Outpatient ❑Inpatient (hospital)
If yes, please list with approximate timeframe:

____

____

Are you currently taking medication for emotional or psychiatric reasons? ❑Yes ❑No
If yes, please list names of medications:

____

Substance use history:

Have you ever received any substance abuse treatment (alcohol or drugs)? ❑None ❑Detox ❑rehab (residential)

If yes, please list:____

____

Current Health and Symptoms

How would you rate your current physical health?: ❑ Excellent ❑Very good ❑Good ❑Fair ❑Poor
Please list any specific health problems or diagnosis you are currently experiencing:

____

____

Relationships:

Are you currently in an intimate or romantic relationship? ❑Yes ❑No, If yes, How long:____________________

How would you rate your relationship with the following people?

Spouse/partner: ❑Doesn't apply, ❑Very good, ❑Good, ❑Satisfactory, ❑fair, ❑Poorly

Your children: ❑Doesn't apply, ❑Very good, ❑Good, ❑Satisfactory, ❑fair,, ❑Poorly

Peers: ❑Doesn't apply, ❑Very good, ❑Good, ❑Satisfactory, ❑fair, ❑Poorly

Other people: ❑Doesn't apply, ❑Very good, ❑Good, ❑Satisfactory, ❑fair, ❑Poorly

Family History

Please list any mental health problems or substance abuse within your family:
Indicate the family member with the condition:

____

____

Is there a history of suicidal behavior in your family? ❑Yes ❑No, if yes, please describe:

____

Social

Do you have any siblings? ❑Yes ❑No If so, please list each with ages.

____

____

Who do you turn to for support: (Check all that apply)

❑My partner or spouse ❑Friends ❑ Family ❑My religion/spirituality ❑Myself ❑Other:________________________

What kinds of activities or coping strategies do you use when stressed?

____

____

What do you view to be as your personal strengths and positive qualities?

____

____

When you complete therapy, what will have changed and/or be accomplished?

____

____