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License No. 29215

Name_____ Date_____

Home/Cell Phone_____ Work Phone_____

Address_____

Email_____

Age_____ Birth Date_____

Marital Status_____ Date Married_____

Occupation_____ Education Level_____

In case of emergency, whom shall I contact?

_____ Phone_____

How did you hear about me? Please circle one.
friend/family other professional internet

What brings you to therapy today?_____

_____

_____

Do you have any specific goals for therapy?_____

_____

Do you have any specific concerns or fears with regard to therapy?_____

_____

_____

Have you ever received mental health treatment before? Y N
(If yes, please describe when, how long, and why)_____

_____

_____

Are you currently taking any medication/ are you currently under any other type of treatment? Y N

Medication Dates Provider

_____

_____

_____

Have you ever been hospitalized for mental health reasons? Y N

Hospital and Medications Dates Reasons

_____

_____

_____

_____

Have you ever been the victim of a violent crime? Y N
Please describe.

_____

_____

Do you have any disturbing memories? Y N
Please describe.

_____

_____

Experienced Symptoms. Please check those symptoms you have experienced.

Symptom	Current	Past	Symptom	Current	Past
Headaches	____	____	Restleness	____	____
Dizziness	____	____	Needing less sleep	____	____
Stomach Trouble	___	____	Mood Swings	____	____
Health Issues	___	____	Excess Energy	____	____
Pain	____	____	Feeling Wired	____	____
Tremors/tics	____	____	Confusion	____	____
Alcohol craving	____	____	Elated Mood	____	____
Drug craving	____	____	Excessive spending	____	____
Eating problems	____	____	Racing thoughts	____	____
Sleep problems	____	____	Irritable	____	____
Weight loss	____	____	Impulsive behavior	____	____

Symptom	Current	Past	Symptom	Current	Past
Weight gain	____	____	Grandiose thoughts	____	____
Loss of appetite	____	____	Excessive anger	____	____
Feeling isolated	____	____	Panic Attacks	____	____
Low Energy	____	____	Anxiety	____	____
Feeling worthless	____	____	Physical abuse	____	____
Memory problems	____	____	Sexual abuse	____	____
Suicidal thoughts	____	____	Sexual problems	____	____
Planning suicide	____	____	Relationship problems	____	____
Attempted suicide	____	____	Conflict in family	____	____
Crying a lot	____	____	Unable to have fun	____	____
Fears	____	____	Nightmares	____	____
Always worried	____	____	Fears of losing control	____	____
Concentration Problems	____	____	Unwanted thoughts or Behaviors	____	____
Hear voices others Do not Hear	____	____	See things others Do not See	____	____
Feel people plot Against you	____	____	Constant suspicion Distrust	____	____
Unusual thoughts	____	____	Strange experiences	____	____
Thoughts of Harming someone	____	____	Someone physically Harming you	____	____

Symptom	Current	Past	Symptom	Current	Past
Violent/Aggressive Behavior	____	____	Feeling Others Cause Your Problems	____	____
Intense Fears of Abandonment	____	____	Feeling Like You Can't Do Anything Right	____	____
Fears that Others Will Reject You	____	____	Intense Feeling of Guilt and/or Shame	____	____
Overly Dependent On Others	____	____	Intrusive Thoughts That Won't Leave You	____	____
Significant Lack Of Motivation	____	____	Fears of Socializing or Being Around Others	____	____
Unable to Feel Happy/Satisfied	____	____	Being Easily Startled or "On Edge"	____	____
Feeling Empty	____	____	Always Needing to Be in a Relatinship	____	____

Briefly Describe your family and current primary relationships:

Name Age Relationship How so you get along?

_____

_____

_____

_____

Has any member of your family had emotional or behavioral concerns? Y N

Please describe details:

_____

_____

Have you ever abused drugs/alcohol or been concerned about your drug/alcohol use? Y/N

Have you ever felt you should cut down on your drinking/drug use? Y N
Have people annoyed you by criticizing your use? Y N
Have you ever felt bad or guilty about your use? Y N
Have you ever had to drink or use first things in the morning to steady your nerves? Y N