



Please fill out the following information. All information you provide is protected under our privacy and confidentiality policy.

Kindly fill out this form and bring to your initial session.

Client name: _____
Full name

Name of Parent/Guardian (If under 18 years of age): _____
Full name

Date of Birth: _____ Age: _____ Gender: Male Female

Social Security: _____ Marital Status (Please check one):

Married Domestic Partnership Married Separated Divorced Widowed

How Long: _____ With whom do you reside: _____

Please list names of children & ages: _____

Address: _____
(Number, street, and apt. or suite no.)

City, state, and ZIP code

Home Phone: _____ May we leave a message? Yes No

Cell Phone: _____ May we leave a message? Yes No

Work Phone: _____ May we leave a message? Yes No

E-mail: _____ May we email you? Yes No

*Please note that electronic transmission is not considered to be a confidential medium of communication

Emergency Contact: _____
Full name

Relationship: _____ Phone number: _____

Who may we thank for your referral: _____

Have you previously received any type of mental health services? Yes No

If yes, when and for how long? _____

Previous therapist/practitioner: _____

Have you ever been hospitalized for psychiatric reasons? Yes No

If yes, where, dates, diagnosis and length of stay: _____

Are you currently taking any prescription medication? Yes No

If yes, please list: _____

Have you ever been prescribed psychiatric medication? Yes No

If yes, please list and include date: _____

Have you ever had suicidal thoughts? Yes No

If yes, what was the outcome? _____

How would you rate your current physical health?

- Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing? _____

How would you rate your current sleeping habits?

- Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific problems you are currently experiencing: _____

How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

Please list any difficulties you experience with your appetite or eating patterns: _____

Are you currently experiencing overwhelming sadness, grief or depression? Yes No

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias? Yes No

If yes, when did you begin to experience this? _____

Are you currently experiencing any chronic pain or had any recent surgeries? Yes No

If yes, please describe: _____

Are you currently in a romantic relationship? Yes No

If yes, for how long? _____

On a scale of 1-10 how you rate your satisfaction with this relationship?

Are you currently experiencing any work related issues? Yes No

If yes, please briefly describe: _____

Are you currently experiencing any financial issues? Yes No

If yes, please briefly describe: _____

Are you currently experiencing inability to concentrate? Yes No

If yes, please briefly describe: _____

Are you currently experiencing excessive anger? Yes No

If yes, please briefly describe: _____

Are you currently experiencing any type of addictive behavior (ie. gambling, internet pornography)?

Yes No

If yes, please briefly describe: _____

FAMILY MENTAL HEALTH HISTORY

Please identify if there is a family history of any of the following. If yes, please indicate the family members relationship to you in the space provided.

- Alcohol/substance abuse Yes No _____
- Anxiety Yes No _____
- Depression Yes No _____
- Eating Disorders Yes No _____
- Obesity Yes No _____
- Obsessive Compulsive behavior Yes No _____
- Schizophrenia Yes No _____
- Suicidal Attempts Yes No _____

Are you currently employed? Yes No

If yes, what is your current employment situation? _____

Do you enjoy your work? Is there anything stressful about your current work? _____

Do you have any legal issues Yes No

If yes, please explain: _____

What is the status of your case? _____

Are you spiritual or religious? Yes No

If yes, describe your faith or belief: _____

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

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

What would you like to accomplish and gain out of your time in therapy? _____

