**PERSONAL INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| First Name: | Middle Initial: | Last Name: | Today’s Date: |
| Mailing/Street Address:  | City: | State: | Zip: |
| Living area: Home Apartment Mobile Home Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ | Home:Own Rent | Highest grade or degree completed: | Are you currently a student?Yes No |
| Preferred Phone:Home Cell Work | May we leave a message? (Not confidential) Yes No  | Email Address: | May we email You? (Not confidential) Yes No  |
| Other Phone:Home Cell Work | May we leave a message?Yes No  | Birth Date: Age: | Sex:M F |
| Marital/Partnership Status:  Single  Married  Cohabitating  Divorced/Separated  Widowed |
| Contact in Case of Emergency: Spouse/Partner Parent Friend Relative Neighbor | Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Cell Work |
| Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any cultural things you would like to tell me about? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Any legal issues in the past or currently? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you or spouse view Pornography? Yes No Never Have If yes, How often Daily Weekly Monthly Yearly Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, have you tried to quit? Yes No How many times: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**SPOUSAL/PARTNER INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Spouse/Partners First Name: | Middle Initial: | Last Name: | Marriage  CohabitatingDate: |
| Mailing/Street Address:  | City: | State: | Zip: |
| Preferred Phone:Home Cell Work | May we leave a message? (Not confidential) Yes No | Birthdate: | Sex: M F  |
| Employer Name: | Employers Address: |

**CHILDREN’S INFORMATION: List All Children**

|  |  |  |  |
| --- | --- | --- | --- |
|  **First & Last Name:** | **Birthdate:** | **Lives with You?** | **Sex:**  |
|  |  | Yes No | M F |
|  |  | Yes No | M F |
|  |  | Yes No | M F |
|  |  | Yes No | M F |
|  |  | Yes No | M F |

**EMPLOYMENT INFORMATION:**

|  |  |  |
| --- | --- | --- |
| Company: | Company’s Address: | Company’s Phone: |
| Do you enjoy your work?  Yes  No  | Are there any unusual stressors with your current work? Yes No If Yes, List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Unemployed? Yes  No  | Reason for unemployment: Fired Lost Job Just graduated Injured Other (explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**INSURANCE INFORMATION:**

|  |  |  |
| --- | --- | --- |
| Insurance Company Name | Insurance Company Address: | Phone: |
| Policyholder: | Policyholders date of birth: | Applicant’s relationship to policy holder:Self Spouse Child Other: \_\_\_\_\_\_ |
| Policy Number: | Group Number: | Co-Pay Amount: |
| **PAYMENT FOR SERVICE*: All insurance Co-payments are due at the beginning of each therapy session. Payments can be made in the form of Cash, Check, Visa, MasterCard, and Discover.******Thank you.*** |

**SPIRITUALITY/ RELIGION:**

|  |  |
| --- | --- |
| Religious Affiliation, if any: Christian Catholic LDS Muslim Hindi Buddhist Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Actively Involved Member?  Yes  No Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you consider yourself to be religious or spiritual? Yes No  | Spiritual Practices? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**COUNSELING HISTORY:**

|  |
| --- |
| What would you like to accomplish out of your time in therapy? \_\_\_\_\_\_\_\_\_\_­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ Yes □ NoIf yes, Please list the previous therapist/practitioner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Have you ever been prescribed psychotropic medication (e.g. for depression, anxiety, etc.?) □Yes □NoIf yes, Please list & provide dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Check the main reason(s) you have decided to seek counseling at this time? Anxiety Panic Attacks ADHD (Impulsive/Inattentive) Anger Phobias Sleep Issues Mood Swings Self-esteem Issues Depression Energy Issues (Hyper or Fatigue) Difficulty Concentrating Grief/Mourning OCD/Compulsiveness Chronic Pain Sexual Issues Trust Issues Work Issues Sent to therapy Weight/Diet Concerns  Divorce Other reason, please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Suicidal thoughts**, if so how often? Everyday Weekly Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Thoughts of harming others**, if so how often? Everyday Weekly Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Adult/Child Abuse** -- Mental Physical Sexual Emotional **Relationship Issues** -- Parenting Marital/Cohabitating Sibling Friends Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**GENERAL HEALTH & MENTAL HEALTH INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Primary Physicians: | Clinic: | Address: | Phone: |
| Last date seen: | Current Diagnosis: | List of medications: |
| How would you rate your current physical health? (Please circle)1 2 3 4 5 6 7 8 9 10***Poor Satisfactory Very Good*** | Please list any specific health problems you are currently experiencing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| How would you rate your current sleeping habits? (Please circle)1 2 3 4 5 6 7 8 9 10***Poor Satisfactory Very Good*** | Please list any specific sleep problems you are currently experiencing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ­­­­­­­­­­Please list your experience with appetite or eating patterns.1 2 3 4 5 6 7 8 9 10***Picky eater Routine Eater Binge Eater*** | Do you drink alcohol? Yes No Never If yes how often: Daily Weekly  Monthly Occasionally |
| What types of exercise to you participate in: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | How many times per week do you generally exercise? 1-2X 3-4X 5-7X Other \_\_ |
| Do you engage recreational drug use? Yes No Never Have  | If yes, how often: Daily Weekly Monthly Occasionally |
| Are you currently in a romantic relationship? Yes No If yes, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_ | How would you rate that relationship? 1 2 3 4 5 6 7 8 9 10***Poor Satisfactory Very Good*** |
| Are there any recent significant life changes or stressful events? If so list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Were there any significant traumatic past or current events in your life?If so list: \_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**FAMILY MENTAL HEALTH HISTORY:** In the section below identify if there is a **Family History** of any of the following. **If yes**, please indicate the family member’s relationship to you.

|  |
| --- |
| ***If Married/Cohabitating***: Please rate the quality of your immediate family relationships:1 2 3 4 5 6 7 8 9 10***Poor Satisfactory Very Good*** |
| Please rate the quality of your family of origin relationships:1 2 3 4 5 6 7 8 9 10***Poor Satisfactory Very Good*** |
| ***Alcohol/Substance Abuse***: Yes No Parent Sibling Grandparent Other relative, Who:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Anxiety:*** Yes No Parent Sibling Grandparent Other relative, Who:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***ADHD (Inattentive/Impulsive:*** Yes No Parent Sibling Grandparent Other relative, Who:\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Depression:*** Yes No Parent Sibling Grandparent Other relative, Who:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Domestic Violence***: Yes No Parent Sibling Grandparent Other relative, Who:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Eating Disorders:*** Yes No Parent Sibling Grandparent Other relative, Who:\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Obesity:***  Yes No Parent Sibling Grandparent Other relative, Who:\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Obsessive Compulsive Behavior:***Yes No Parent Sibling Grandparent Other relative, Who:\_\_\_\_\_\_\_\_\_\_\_ |
| ***Schizophrenia:*** Yes No Parent Sibling Grandparent Other relative, Who:\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Depression & Suicide Attempts:*** Yes No Parents Sibling Grandparent Other relative, Who:\_\_\_\_\_\_\_\_\_\_\_\_ |

**ADDITIONAL INFORMATION:**

*(Please feel free to use the back if needed)*

What do you consider to be some of your strengths? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your main goals for therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is there anything else you would like me to know? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_