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Name:_____

Address:_____

Contact Information:	May I contact you here?	Yes	No
E-mail:_____		____	____
Home Phone:_____		____	____
Cell Phone:_____		____	____
Work Phone:_____		____	____

Personal Information:

What is your reason for coming to counseling now?_____
_____

What are your goals for therapy?_____
_____

Birthdate:_____

Single___Married____ Separated___Divorced___Widowed___Other____

If in relationship, partner's name:_____
Length of relationship:_____

Child/Children's names and ages:
_____
_____
_____

Who lives in your home with you?

Name	Sex	Age	Relationship

Work:

Are you currently employed?_____If yes, where?_____
How long have you been at this job?_____
Do you enjoy your work?_____
College/Education:_____
Military Service?_____

Health History:

How would you describe your physical health right now? (circle one):
Poor Unsatisfactory Satisfactory Good Excellent

Please list any persistent or chronic health issues or current health concerns:_____
_____

Primary Care Physician:_____

Are you currently being treated for a medical problem? If so, briefly describe (and please include any medications you are currently taking):

How would you describe your diet: (circle one):
Poor Unsatisfactory Satisfactory Good Excellent

Are you having any significant changes or problems with your eating habits or weight? If yes, please describe:_____
_____

How many times a week do you exercise? ____ How long each time?_____

Are you having any problems with your sleep? ____ If yes, please describe:_____
_____

Alcohol and recreational drug use:

Type of Drug/Alcohol	First Used	Frequency of Use

Do you or anyone close to you worry about your use?_____
If yes, please describe:_____
_____

Have you seen a counselor before? Briefly describe, including dates, what you were in counseling for, whom you saw and if it was helpful:
_____
_____
_____

Are you currently taking psychiatric medications?_____ If yes, please list:

Have you taken psychiatric medications in the past? If yes, please list and approximately when you took them and for how long:

Have you ever been hospitalized for a psychiatric problem?
Briefly describe (including dates and diagnosis if you know it:

Are you currently experiencing overwhelming sadness, grief or depression?_____ If yes, for approximately how long?_____
Are you having any suicidal thoughts?_____
Have you ever made a suicide attempt?_____
If yes, when and did you get help?_____

Are you experiencing significant anxiety or panic attacks? _____If yes, for approximately how long?_____

Have you ever experienced extreme mood swings?_____If yes, when:

Trauma history:
Have you experienced an assault or an event(s) where you were concerned that your life was in danger? _____ If yes, briefly explain when and what happened:

Have you witnessed a violent death or assault?____If yes, when and what happened?_____

Do you have a history of child abuse?_____If yes, please describe briefly:

Do you feel this history is causing problems in your current life?_____
If yes, please describe:_____

Family Mental Health History

Has anyone in your family (immediate family members or grandparents, aunts, uncles, etc.) experienced difficulties with the following?

Mental Health Issue Family Member Affected

Depression_____
Bipolar disorder_____
Anxiety disorder_____
Schizophrenia_____
Alcohol/Substance abuse;_____
Eating disorders_____
Trauma history_____

Your Current Stressors: (describe briefly)

Relationship_____
Financial_____
Illness (self or family)_____
Legal_____
Sleep disorders_____
Job Problems_____
Eating disorder_____
Substance Abuse (or concern for loved one's use of drugs/alcohol)
_____
Other:_____

In the last year, have you experienced any major life changes? Please describe:_____
_____

Is religion or spirituality important to you? _____If yes, briefly describe your belief or faith_____
_____

Emergency Contact Name_____
Relationship_____ Phone Number_____
Address:_____

Client's signature_____Date:_____