GENERAL INFORMATION

Client Name ____
Address ____
City ______________________________ Zip ____________
Home ___________ Cell ___________ Work ___________
Email ____

Is it safe/permissible to leave a message at your home/work/cell number? If no, please specify how contact attempts should be handled:
____
____

Birth date _______________ Age ______ Sex _______ Height ________ Weight ________
SS # _______________________________________

Marital Status:

- ❑ Single
- ❑ Separated (How long) ______
- ❑ Engaged- Wedding Date _____
- ❑ Widowed (How long) _____
- ❑ Married (How long) ______
- ❑ Partnership (How long) _____
- ❑ Divorced (How long) ______

Living Situation (house, hotel, room, apartment, etc.) ___________________________________

Are you satisfied with your present living conditions? _____ Describe: ___________________
____

List people living in your home:
____
____
____

Education Level Completed: ____

Employer ____________________ Job Title __________________________ How long _____
Address: ____
City _____________________________________ Zip ____________

How many times have you changed jobs in the past three years? _________________________

Are you satisfied with your present employment? ______________________________________
____

Person who referred you for psychotherapy __________________________________. Could this person be contacted to thank them for the referral? _____ If yes, please initial

Major Medical Problems in the past five years: ______________________________________
____
____

Primary Care Physician ______________________________ Telephone _______________
Date of last exam: ____________________________

PRIMARY CONCERN

What is the reason are you seeking therapy at this time? How long has this been going on, what behaviors/feelings are connected to it? How long have you tried to correct them? ___________
____
____
____
____
____

When did this matter begin to be an issue for you? What happened to make you seek professional help? What might be going on in your life that may be related to this? __________
____
____
____
____
____

Have you experienced a similar concern at any other time? When? What helped? ___________
____
____
____
____
____

Are you or have you ever been on medication for an emotional/mental concerns? If so, list the problem and prescription information. ____
____
____

Other medications, including dosage and length of time you have taken each:
____
____

Do you use any substance where the urge is difficult to control or interferes with your job/relationships? If yes, please describe what is used and the impacts: ____________________
____
____

Describe spiritual/religious beliefs. Are there any issues that need to be addressed in therapy?

List strengths/talents you possess:

List current support system:

List interests and activities:

PREVIOUS PSYCHOTHERAPY AND RELATED ISSUES

Have you consulted a psychotherapist or been involved with a mental health agency before? Please indicate the approximate date, clinician, your reason(s) for seeking psychotherapy at that time, and whether or not therapy was helpful.

Have you ever felt like hurting yourself, including self-mutilation and suicide attempts? If you have ever done so, please explain.

Have you ever felt like hurting someone else? If you have ever done so, please explain.

Have you ever been hospitalized for an emotional/mental health reason? If so, please explain.

Are there or have there been legal concerns? If so, please explain.

FAMILY OF ORIGIN

Who was your primary caregiver? ____

Describe the relationship: ____
____
____

Biological Father: ________________________________ Age: ____________
If deceased, date of death: ____________________
Biological Mother: ________________________________ Age: ____________
If deceased, date of death: ____________________

Describe their marriage (If divorced, please list the year it occurred): ____________________
____
____

If a divorce, when? ________________
If repartnered, list the year of the marriage and describe any children who joined your family:
____
____

List siblings by birth order:

Name	Sex	Current Age
____________________________	_____	__________
____________________________	_____	__________
____________________________	_____	__________
____________________________	_____	__________

Are there family members with mental health concerns or substance abuse issues? If so, please list:
____
____

Is there a history of violence, verbal, physical, or sexual abuse in your family? If yes, please describe: ____
____
____

List any other information that might be helpful

CURRENT SYMPTOMS/CONCERNS CHECKLIST

Please check all that apply

- ❑ Allergies
- ❑ Anger
- ❑ Asthma
- ❑ Back pain
- ❑ Black outs
- ❑ Cancer
- ❑ Changes in memory
- ❑ Chronic Pain
- ❑ Clenching jaw/grinding teeth
- ❑ Cold hands/feet
- ❑ Colds/flu
- ❑ Confusion
- ❑ Constipation/diarrhea
- ❑ Cutting
- ❑ Decision making, procrastination
- ❑ Decreased productivity
- ❑ Depression, low mood, sadness
- ❑ Dizziness/fainting spells
- ❑ Don't like being touched
- ❑ Dry mouth
- ❑ Emptiness
- ❑ Fatigue, exhaustion
- ❑ Fear
- ❑ Feelings of failure
- ❑ Feelings of inadequacy
- ❑ Grief, mourning
- ❑ Headaches
- ❑ Head injury
- ❑ Hear things others don't
- ❑ Heart palpitations
- ❑ Heart trouble
- ❑ High/low blood pressure
- ❑ Hopelessness
- ❑ Impulsiveness, low self-control
- ❑ Increased need for sleep
- ❑ Indigestion
- ❑ Infidelity
- ❑ Irritability
- ❑ Loneliness
- ❑ Loss of appetite
- ❑ Loss of faith in God
- ❑ Loss of interest in activities
- ❑ Mood swings
- ❑ Muscle tension/cramps
- ❑ Nervousness
- ❑ Numbness/tingling
- ❑ OB/GYN disorder
- ❑ Overeating/increased appetite
- ❑ Panic or anxiety attacks
- ❑ Parenting
- ❑ Perfectionism
- ❑ Pessimistic attitude
- ❑ Physical trauma
- ❑ Poor concentration, distractibility
- ❑ Productivity decrease
- ❑ Racing thoughts
- ❑ Recent gain in weight
- ❑ Recent loss in weight
- ❑ Religious doubts/fears
- ❑ See things others don't
- ❑ Self-esteem
- ❑ Self-care
- ❑ Sexual difficulties
- ❑ Shyness
- ❑ Skin problems
- ❑ Smoking and tobacco use
- ❑ Social withdrawal
- ❑ Sexually transmitted disease
- ❑ Sleep difficulties
- ❑ Stress, tension
- ❑ Substance use/dependence
- ❑ Tearful or crying
- ❑ Tension/difficulty relaxing
- ❑ Thyroid disease/trouble
- ❑ Troubling dreams
- ❑ Ulcers
- ❑ Underweight
- ❑ Vocational direction
- ❑ Vomiting
- ❑ Worry

Any other concerns or issues:

____

____

____