GENERAL INFORMATION

Client Name _____
Pronouns _____
Address _____
City _____ Zip _____
Home _____ Cell _____ Work _____
Email _____

Birth date _____ Age _____ Height _____ Weight _____

Relationship Status: _____
If partnered, are there any concerns that need addressing? _____
_____

Describe your present living conditions and people living in your home: _____
_____
_____

Occupation _____ Job Title _____ How long _____

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.

PRIMARY CONCERN

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

Goals to work on in therapy _____
_____
_____
_____

How have components of your sexual orientation or gender impacted your life thus far? _____
_____
_____
_____
_____

What has been your experience around disclosures? _____
_____
_____
_____
_____

Are there any disclosures you intend to do in the future? What kind of support are you looking for to move forward? _____
_____
_____
_____
_____

If you have a spiritual/religious path, how does that impact/inform you? _____ _____
_____
_____
_____
_____

What is your current involvement in the LGBTQ+ community? _____
_____
_____
_____
_____

Gender Specific Question
Are there any procedures you have undergone or are considering? Is a letter supporting this journey part of your reason for seeking therapy? _____
_____
_____
_____
_____

Gender Specific Question
What have been the impacts of any procedures you have had? What do you anticipate will be the implications of any procedures you are considering? _____ _____
_____
_____
_____
_____

Specify all psychotropic medications you are currently taking, for how long, and for what reason. Provide the dosage and when they are to be taken. Please describe the impacts they have on you and your quality of life._____
_____
_____
_____

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: _____
_____
_____

On a scale from 0 to 10 (0=very poor, 10=the very best), rate your sleep. Provide reasons for your rating: _____
_____
_____
_____

Describe diet and eating habits: _____
_____
_____
_____

List current support system:
_____
_____
_____

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, any diagnoses given 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 describe._____

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

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

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

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 to the degree you feel comfortable disclosing: _____

CURRENT SYMPTOMS/CONCERNS CHECKLIST

Please check all that apply and rate severity on scale of 0-10

- ❑ Anger
- ❑ Black outs
- ❑ Cancer
- ❑ Changes in memory
- ❑ Chronic Pain
- ❑ Clenching jaw/grinding teeth
- ❑ Cold hands/feet
- ❑ Confusion
- ❑ Constipation/diarrhea
- ❑ Crying
- ❑ Cutting
- ❑ Decreased productivity
- ❑ Depression, low mood, sadness
- ❑ Difficulty making decisions
- ❑ Disappointment in myself
- ❑ Dizziness/fainting spells
- ❑ Don't like being touched
- ❑ Eating Disorder: _____
- ❑ Emptiness
- ❑ Fatigue, exhaustion
- ❑ Fear
- ❑ Feelings of failure
- ❑ Feelings of inadequacy
- ❑ Grief
- ❑ Guilt
- ❑ Headaches
- ❑ Head injury
- ❑ Hear things others don't
- ❑ Heart palpitations
- ❑ High/low blood pressure
- ❑ Hopelessness
- ❑ Impulsiveness, low self-control
- ❑ Infidelity
- ❑ Irritability
- ❑ Loneliness
- ❑ Loss of appetite
- ❑ Loss of interest in things I used to enjoy
- ❑ Low self-esteem
- ❑ Mood swings
- ❑ Nervousness
- ❑ Numbness/tingling
- ❑ OBGYN disorder
- ❑ Overeating/increased appetite
- ❑ Pain
- ❑ Panic attacks
- ❑ Parenting
- ❑ Perfectionism
- ❑ Pessimistic attitude
- ❑ Physical trauma
- ❑ Poor concentration, distractibility
- ❑ Racing thoughts
- ❑ Recent changes in weight: _____
- ❑ Religious doubts/fears
- ❑ See things others don't
- ❑ Sexual difficulties
- ❑ Smoking and tobacco use
- ❑ Social withdrawal
- ❑ Self-blame
- ❑ Sexually transmitted disease
- ❑ Sleep difficulties: _____
- ❑ Substance use/dependence
- ❑ Tearful or crying
- ❑ Tension/difficulty relaxing
- ❑ Thyroid disease/trouble
- ❑ Troubling dreams/Nightmares
- ❑ Vocational issues
- ❑ Vomiting
- ❑ Worry

Any other concerns or information that would be important to know: _____
_____
_____
_____
_____
_____
_____