GENERAL INFORMATION

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

Birth date _______________ Age ______ Height ________ Weight ________

Relationship Status ____

Gender ____

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

List 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? ______________________
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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? __________
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Goals to work on in therapy ____
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Have you experienced a similar concern at any other time? When? What helped? ___________
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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.____
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____

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

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

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

Have you ever felt like hurting someone else? If you have ever done so, please describe.
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Have you ever been hospitalized for an emotional/mental health reason? If so, please describe.
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____

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

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

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: ___________________________________
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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: ______________________________
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