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Welcome to therapy. The below questions are a way for me to get some background on who you are and what you are going through. Please answer to whatever extent you feel comfortable, and if you would prefer to answer in person or wait to share anything that is fine too. Feel free to use the backside if you need more room for answers. Thanks.

General:

Name ________________________________ Date __________________________

Pronouns ______________________________

Address _______________________________ Home Phone ___________________

_______________________________________ Cell Phone ____________________

E-Mail _________________________________ Referred by ___________________

Age _______ Date of birth ___________________

Relationship status _____________________ Educational level _______________

Occupation _____________________________

Emergency contact information ____

Relationship to you ______________ Do I have permission to contact this person ________

Areas of Concern

Issues/concerns causing you to seek therapy? Please describe.

____

____

____

____

____

Specific goals with regard to your therapy? ________________________________

____

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____

____

Particular concerns/fears with regard to therapy?

____

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____

____

Psychological History (Note that I will not contact anyone without your signed permission-unless emergency)

Have you been in therapy before? _______

When and for how long? ____

____

____

Focus?

____

____

____

Have you ever been subjected to one or more psychological tests? ____________For what?___________________________

Have you ever been hospitalized for mental or emotional problems?________When and for how long?____________

____

Why were you hospitalized?

____

____

Are you currently taking any prescription medications for psychological issues? __________

Medication names & dose:____

____

____

How long have you been on the medications? ____

How are they working for you? ____

Any past medications for a psychological issue? ___________ When and for how long?____________________________

____

Have you ever attempted suicide? _______ When _______________

Describe attempt:

____

Are you currently having any suicidal thoughts? Please describe____

____

Any recent times of seriously considering suicide? ___________

What significant life changes or stressful events have you experienced recently?

____

____

____

____

Please describe your childhood

____

____

____

____

____

____

Were your parents or caregivers frightening or frightened (please describe)? ______________________________

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____

____

Were you ever left alone when upset or not emotionally supported when needed?

____

What happened when you cried as a child? ____

____

Were you ever subjected to verbal, physical, emotional, sexual abuse? Please describe.

____

____

____

____

Have you ever been a victim of a violent crime? Please describe ____________________________________

____

____

Please indicate if you are having any of the following problems, or if you had them in the past:

	I have this now	I had this in the past
Difficulty falling asleep or staying asleep	____	____
Sleeping too much	____	____
Change in appetite, weight loss, or weight gain	____	____
Frequent crying	____	____
Panic attacks or anxiety attacks	____	____
Thoughts of killing myself	____	____
Attempts to kill myself	____	____
Problems concentrating	____	____
Problems remembering things	____	____
Periods of daily sadness lasting more than two weeks	____	____
Easily startled	____	____
Periods of time when I seem to need very little sleep	____	____
Often feel as if I am running like a motor	____	____
Racing thoughts	____	____
Can’t stop remembering upsetting past events	____	____
Difficulty controlling my temper	____	____
I physically hurt other people	____	____
I break things sometimes	____	____

	I have this now	I had this in the past
I worry a lot	____	____

I purposely cut or hurt myself	____	____
I feel tired almost every day	____	____
Feelings of unreality	____	____
Make myself throw up in order to lose weight	____	____
Use laxatives or diuretics	____	____
Exercise excessively to lose weight	____	____
I have thoughts that I can't get out of my head	____	____
I engage in repetitive behavior	____	____
I sometimes see things that others don't	____	____
I often feel like I am an outsider	____	____
Avoid particular locations or situations	____	____
Worry that something is wrong with my body	____	____
Frequent arguments with the people I live with	____	____
I hear voices inside my head	____	____
I frequently act impulsively	____	____

Other /Comments:

____

____

FAMILY HISTORY OF MENTAL HEALTH DIAGNOSES:

In the section below please identify if you or a family member has ever been diagnosed with any of the following. If yes, please indicate who received the diagnosis (self, mother, father, sibling, grandmother, uncle, etc.).

Diagnosis	Who Received Diagnosis

____ ADHD ____

____Alcohol/Substance Abuse ____

____Anxiety ____

____Bipolar Disorder ____

____Depression ____

Diagnosis Who Received Diagnosis

____Domestic Violence ____

____Eating Disorders ____

____Obsessive Compulsive Disorder ____

____Phobias/Panic Disorder ____

____Schizophrenia ____

____Suicide Attempts ____

____Other (Please specify): ____

Please describe your living situation (e.g. house, apartment, dorm, homeless, other):____

____

How long have you lived there? ___________ Is this temporary or permanent? ______________________

Please describe your household (members, ages, relationship to you): ____

____

Partner's name, age, gender, and how long together: ____

Medical History

Have you ever been diagnosed with a serious illness? Please describe____

____

Please describe your overall health today____

____

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? ______

Please describe. ____

____

Have you ever been in a 12-step program? Please describe. ______________________________

____

Do you smoke cigarettes? _____ How much? ____________ For how long? _______________

Do you drink alcohol? ______Average in a week?_____________________

caffeine? ________Sugar?_________Cannabis? ______________

Do you currently use other (street or un- prescribed) drugs? Please briefly describe your use

____

Family of Origin History

Mother's name, age, living/deceased, patient's age at the time of mother's death, description of relationship with mother.

____
____
____
____
____
____

Father's name, age, living/deceased, patient's age at the time of father's death, description of relationship with father:____

____
____
____
____
____

Names and ages of siblings and relationship: ____

____
____

Other Information

Please describe your spiritual identity/orientation:____________________________________

____

Please describe your interests/hobbies

____
____

What do you consider to be some of your strengths? _____________________________________

____

What is your current relationship/experience in relation to money:_________________________

____

Past?

How is your self-care (diet, sleep, exercise)?

How is your support system (friends, Family)?

What is your current stress level in relation to external stressors or internal experience?

How do you feel about your relationship to the internet or email? How frequent is your usage?   Concerns?

How do you feel about your sexuality?

Any particular concerns or considerations?

Do you have an active sex life currently? ____

Concerns/considerations?____

____

____

Do you have concerns about how you handle anger or communication (please describe)?_ ____________________

____

____

What is your relationship to commitments and plans: ____

____

____

____

What has been your past experience with therapy (include individual and if any group/workshops,Helpful, Unhelpful?):____

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What if any trauma have you experienced in your past? This is any event in which you felt threatened on a physical level. This can include being witness to domestic violence or any other violence or verbal attack. Any kind of assault or way in which a physical boundary was crossed (including corporal punishment or physical discipline as a child), sexual violation, accidents, war related violence, abandonment as a baby or child (due to neglect or adoptive relinquishment) or any other experience in which you felt threatened/overwhelmed at the nervous system level. Either one time or on an ongoing basis. (use back if needed):

Any other information you want to share here?: ______________________________