Identifying Information

- Name and Preferred/Nick Name:
- Gender:
- Ethnicity:
- Birthday and Age:
- Address:
- Best Contact Number:
- Email:
- May we leave messages via: ☐Person other then you ☐Voicemail ☐An Email ☐ Text Message

Emergency Contact

- Emergency Contact Name:
- Relationship:
- Contact Number:

Presenting Problem

- What is the presenting problem?
- Have you previously suffered from this presenting problem? ☐ Yes ☐ No
- If Yes, previous professional(s) seen for complaint, describe treatment:
- Aggravating Factors:
- Relieving Factors or Coping Techniques:

Current Symptoms

(Check all the apply)

☐ Anxiety ☐ Appetite Issues ☐ Avoidance ☐Crying Spells
☐ Depression ☐ Excessive Energy ☐ Libido Change ☐Guilt
☐ Hallucinations ☐ Impulsivity ☐ Irritability ☐Fatigue
☐ Loss of Interest ☐ Panic Attacks ☐ Racing Thoughts ☐Risky Activity
☐ Sleep Changes ☐ Suspiciousness ☐ Feeling of Worthlessness

Current Additional Stressors

(Check all that apply)

☐ Financial	☐ Marital/Relationship	☐ Legal	☐ Educational
☐ Occupational	☐ Medical	☐ Family	☐ Other:

Medical History

- Exercise Frequency:
- Exercise Type:
- Allergies:
- Current Medications:
- Previous Diagnoses/Mental Health Treatment:
- Previously treated by:
- Previous Medication:
- Dates Treated:
- Previous Medical Conditions:
- Previous Surgeries:

Family History

- Were you adopted? ☐ Yes ☐ No If yes, at what age?
- Are your parents married? ☐ Yes ☐ No
- What is your relationship with your mother like?
- What is your relationship with your father like?
- Did your parents divorce? ☐ Yes ☐ No If yes, how old were you?

- Did your parents remarry? ☐ Yes ☐ No If yes, how old were you?
- Who raised you?
- Where did you grown up?
- Siblings and Ages
- Family member medical conditions
- Family member mental conditions

Present Situation

- Work: ☐Full-time ☐Part-Time ☐Student ☐Unemployed ☐Disabled ☐Retired ☐Other
- Are you married? ☐ Yes ☐ No If yes, specify date of marriage
- Are you divorced? ☐ Yes ☐ No If yes, specify date of divorce
- Prior marriages? ☐ Yes ☐ No If yes, how many?
- Prior engagements? ☐ Yes ☐ No If yes, how many?
- What is your sexual orientation?
- Are you sexually active? ☐ Yes ☐ No
- If you currently have a partner, how is your relationship?
- Do you have child(ren)? If yes, how is your relationship with your child(ren)?
- Are you a member of a religion/spiritual group? ☐ Yes ☐ No
- Have you ever been arrested? ☐ Yes ☐ No If yes, when and why?

Substance Use

Have you ever tied any of the following?

(Check all the apply)

☐ Alcohol	☐ Tobacco	☐ Marijuanna
☐ Heroin	☐ Cocaine	☐ Hallucinogens (LSD)
☐ Stimulants (Pills)	☐ Ecstasy	☐ Methadone
☐ Tranquilizers	☐ Pain Killers	☐ Methamphetamines

- If yes to any, list frequency/dates of use:
- Have you ever been treated for drug/alcohol abuse? ☐ Yes ☐ No If yes, when?
- Do you smoke cigarettes? ☐ Yes ☐ No If yes, how many per day?
- Do you drink caffeinated beverages? ☐ Yes ☐ No If yes, how many per day?
- Have you ever abused prescription drugs? ☐ Yes ☐ No If yes, which ones?

Suicidal Ideation

- Thoughts of Death? ☐ Yes ☐ No
  - If yes, are the thoughts current? ☐ Yes ☐ No
  - If yes, is there a plan? ☐ Yes ☐ No
- Do you have access to weapons or other means of harm? ☐ Yes ☐ No If yes, Please
- Previous Attempts? ☐ Yes ☐ No If yes, please explain.
- History of self-injurious behavior? ☐ Yes ☐ No If yes, please explain.

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