Name: _____ Age: _____ Gender: _____

Date of Birth: _____ / _____ / _____

Race/Ethnicity: _____ Marital Status: _____

Today's Date: _____/_____/_____ Appointment Time: _____

What are the main problems you are seeking help with today?

Problem	When did It Start?	What Caused It?	What Makes it Better, If Anything?
1.			
2.			
3.			

What are your main goals for counseling?

1.

2.

3.

Did someone recommend you receive counseling (if so, who?)

Have you been in counseling before?

When was the last time?

Are you currently seeing a psychiatrist or psychiatric nurse practitioner?

What mental health diagnoses have you been given before?

Who do you live with?

Do you have children? If so, how many?

If you have a job, what do you do and how do you like it?

Our relationships and experiences – even those in childhood – can affect our health and well-being. Difficult child experiences are very common. Please tell us whether you have had any of the experiences listed below, as they may affect your mental and physical health.

Below is a list of 10 categories of Adverse Childhood Experiences (ACEs). From the list below, please place a checkmark next to each ACE category that you experienced prior to your 18th birthday.

● Did you feel you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?	
● Did you lose a parent through divorce, abandonment, death, or other reason?	
● Did you live with anyone who was depressed, mentally ill, or attempted suicide?	
● Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?	
● Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other?	
● Did you live with anyone who went to jail or prison?	
● Did a parent or adult in your home ever swear at you, insult you, or put you down?	
● Did a parent or adult in your home ever hit, beat, or physically hurt you in any way?	
● Did you feel that no one in your family loved you or thought you were special?	
● Did you experience unwanted sexual contact?	

Have you ever been married? __Yes __ No If so, how many times? _____

How many serious relationships have you had as an adult, including marriages? _____

Are you in a marriage or serious relationship now? ___ Yes ___ No If so, for how long? _____

In any of your marriages or serious relationships, have any of the following things happened?

___ Threats of violence

___ Hitting, slapping, or punching

___ Having your partner or spouse use you for money

___ Having a partner or spouse cheat on your with someone else

___ Being suddenly abandoned by a partner or spouse

___ Having a partner or spouse who was in prison or engaging in serious criminal activity

___ Having a partner or spouse who was addicted to alcohol or drugs

___ Having a partner or spouse who made you feel unloved or undesirable

Have you ever been treated in a psychiatric hospital? ___ Yes ___ No

If you have been treated in a psychiatric hospital, how many times? _____

How old were you the first time you were treated in a psychiatric hospital? _____

When was the last time you were treated in a psychiatric hospital? _____

Have you ever made a suicide attempt? ____ Yes ____ No

If so, how many times have you attempted suicide? _____

If you have attempted suicide, how old were you the first time? _____

If you have attempted suicide, when was the last time you attempted it? _____

Have any of your close friends or family members ever died by suicide? _____

Do you currently wish to end your life? ____ Yes ____ No

Have you recently made plans about how to end your life? ____ Yes ____ No

Have you ever hurt your body on purpose, such as by cutting or burning yourself? ___ Yes ____ No

If so, how old were you the first time? _____

If so, when was the last time you hurt your body on purpose? _____

Do you have access to guns in your home? ___ Yes ___ No

If you have access to guns, are any guns stored separately from ammunition? ___ Yes ___ No

Put an X next to any drugs you have used in a way that caused problems for you, even if you no longer use them

__ Alcohol

__ Marijuana or Cannabis

__ Pain pills, anxiety pills, or sleeping pills

__ Cocaine

__ Ketamine

__ Methamphetamine (“speed”, “crystal meth”, “meth”)

__ Morphine, heroin, fentanyl

 Answering these questions helps me structure our time and your treatment. If there is any question you do not wish to answer you may leave it blank.

__ PCP (“angel dust”)

__ Magic mushrooms, LSD, Peyote, Ayahuasca

Over the last two weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

2. Feeling down, depressed, or hopeless

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

3. Trouble falling or staying asleep, or sleeping too much

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

4. Feeling tired or having little energy

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

5. Poor appetite or overeating

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

7. Trouble concentrating on things, such as reading the newspaper or watching television

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

9. Thoughts that you would be better off dead, or of hurting yourself

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat Difficult	Very Difficult	Extremely Difficult
[ ]	[ ]	[ ]	[ ]

 Answering these questions helps me structure our time and your treatment.
If there is any question you do not wish to answer you may leave it blank.

Over the last two weeks, how often have you been bothered by the following problems?

1. Feeling nervous, anxious, or on edge

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

2. Not being able to stop or control worrying

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

3. Worrying too much about different things

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

4. Trouble relaxing

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

5. Being so restless that it is hard to sit still

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

6. Becoming easily annoyed or irritable

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

7. Feeling afraid, as if something awful might happen

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat Difficult	Very Difficult	Extremely Difficult
[ ]	[ ]	[ ]	[ ]

Do problems with mental health run in your family? Which family members and which problems? Use check marks to show which are problems in your family

	ADHD	Anxiety	Depression	Mania	Alcohol Problems	Drug Problems	Violence	Criminality
Mother								
Father								
Siblings								
Grandparents								
Children of Mine								

Have you ever heard voices other people cannot hear? This question is about hallucinations, not about dreams, nightmares, things that happened on drugs, or while going to sleep or waking up.

_ Yes _ No

Has this happened in the past month? _ Yes _ No

Have you ever seen things others cannot see? This question is also about hallucinations, not about dreams, nightmares, drug experiences, or things that happen while going to sleep or first waking up.

_ Yes _ No

Has this happened in the past month? _ Yes _ No

Have you ever gone a few days or more with no sleep or only an hour or two of sleep, **without feeling tired**? This question is about mania, not about chronic insomnia or drug trips or withdrawal from drugs.

_ Yes _ No

Has this happened in the past month? _ Yes _ No

Are you currently having any serious legal problems (divorce, criminal prosecution, lawsuits)?

_ Yes _ No

How many times have you been in a motor vehicle accident, whether your fault or not, or a serious workplace accident? _____

Have you ever been in an accident or had a sports injury that caused you to lose consciousness or black out? _ Yes _ No

Have you ever had a concussion diagnosed by a professional? _ Yes _ No

What you say in psychotherapy is confidential, meaning that your psychologist will not give anyone information about you unless you agree. **But, there are cases where your psychologist does not need your agreement to give information about you.**

- If any patient says that they intend to end their life by suicide, I am allowed to give information to police and ambulances and other people such as family members who need that information to help keep the patient safe.
- If any patient threatens the life or safety of another person, I may be required to give that information to the police and the person being threatened.
- If you tell me about a child who is being neglected or abused, or a child that seems in danger of that to me, then I may be required to call the police or make a child abuse report to a state agency so that child can be protected.

If you have any questions about confidentiality, you may ask me at the beginning of our session.