**DATE:** _____ **NAME:** _____ **DOB:** _____

**Section 1: Presenting Problem**

☐Addictive behavior ☐Anger ☐Anxiety ☐Alcohol/Drug problem ☐Depression ☐Domestic violence/Abuse
☐Eating Disorder ☐Family/Parenting Problems ☐Grief/loss ☐Trauma/Abuse ☐Job problems ☐Legal problems
☐Relationship problems ☐School problems ☐Not sure ☐Other: _____

*Please provide a brief description of why you are seeking Therapy:

How is the problem impacting your daily life? _____

**Section 2: Safety Issues & Concerns**

Have you ever thought of harming yourself or others or trying to take your own life? ☐Yes ☐No

*If No, continue to Section 3.*

Have you had any suicidal thoughts recently? ☐Yes ☐No If yes: ☐Frequently ☐Sometimes ☐Rarely
Do you think or feel this way presently? ☐Yes ☐No
Have you had suicidal thoughts in your past? ☐Yes ☐No
If yes, how long ago? _____ How often? ☐Frequently ☐Sometimes ☐Rarely
Did you ever attempt suicide? ☐Yes ☐No If yes, how many times? _____
When was the first time? _____ When was the last time? _____
How did you try to do it? _____
Do you engage in any form of self-harm? ☐Yes ☐No
If yes, please list _____
Do you think about your own death or about dying? ☐Frequently ☐Sometimes ☐Rarely

**Section 3: Background Information (Identification)**

How do you identify your ethnicity? (select all that apply)
☐Asian ☐Black/African ☐Caucasian ☐Hispanic/Latinx ☐Native American ☐Pacific Islander
☐Prefer not to answer ☐_____
Do you practice a religion? ☐Yes ☐No If yes, what is your faith? _____
If no, do you consider yourself to be spiritual? ☐Yes ☐No
Marital Status: ☐Never married ☐Partnered ☐Married ☐Separated ☐Divorced ☐Widowed
How many times have you been married? _____
If divorced, when (your age or the year)? _____
If widowed, when? _____
How many children do you have? _____ Children's ages? _____
Are you currently in a romantic relationship? ☐No ☐Yes
Name of significant other? _____ Age _____
How long have you been in this relationship? _____
On a scale from 1-10, how would you rate the quality of your relationship (10 being great)? _____
In the last year, have you had any major life changes (e.g., new job, new home, illness, relationship change, etc.)?
_____

**Section 4: *History* of Present Problem**

When did symptoms start (Onset)? _____
How long have symptoms been present (Duration)? _____
How often do you have these symptoms (Frequency)? _____

**Section 5: *Past* Psychiatric History**

Have you ever been placed in a psychiatric hospital or received In-patient treatment? ☐Yes ☐No
If yes, list your age when you were hospitalized and the reason.
Age: _____ Reason: _____
Have you ever seen a counselor, psychologist, or psychiatrist? ☐Yes ☐No
If yes, at what age did you attend sessions? _____ How long did you attend? _____
Reason you attended? _____
Have you received a previous Diagnoses? ☐No ☐Yes _____

Has a doctor ever prescribed medication to help with depression, anxiety, behavior, or mental problems? ☐Yes ☐No
If yes, age when medication was prescribed? _____
Type of medication? _____ To help with what problem? _____

**Section 6: Trauma History**
☐None, does not apply - *continue to Section 7.*
☐I have had exposure or threat of death, serious injury, or sexual violence.
☐I persistently re-experienced a traumatic event with recurrent, involuntary, or intrusive memories.
☐I have nightmares about the trauma.
☐I have flashbacks about the trauma.
☐I feel distress after exposure to trauma reminders.
☐I feel constantly "on-guard" (Hypervigilance).
☐I have been diagnosed with PTSD
Have you been abused sexually, emotionally or physically? ☐No ☐Yes
Please briefly describe any trauma (nature of trauma, when occurred, persons involved, etc.):
_____

**Section 7: Family Psychiatric History**
☐None - *continue to Section 8.*
Or please list history of any mental illness in first degree biological relatives (parents, siblings, offspring):
_____

**Section 8: Medical Conditions & History**
How is your physical health at the present time? ☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Very good
Please list any persistent/chronic physical symptoms or health concerns (***not*** psychiatric or behavioral) which you have been diagnosed with:
_____
Have you ever been hospitalized overnight for medical reasons other than surgery? ☐No ☐Yes List your age when you were hospitalized and the reason: Age: _____ Reason: _____

**Section 9: Current Medications** (medication, dosage, purpose, prescribing physician):
Are you on any prescription medication for *physical/medical* issues? ☐No ☐Yes, please list:
_____
Are you currently taking any prescription *psychiatric* medications? ☐No ☐Yes, please list:
_____

**Section 10: Substance Use** (Alcohol & Drugs)
Do you consume alcohol regularly? ☐Daily ☐Weekly ☐Monthly ☐Rarely ☐Never
In one month, how many times do you have 4 or more drinks in a 24-hour period? _____
Has drinking alcohol ever caused problems for you? (other people tell you to drink less, legal issues, relationship problems, etc.)? ☐No ☐Yes If yes, at what age did alcohol start to cause problems? _____
When did you have your last drink? _____
How often do you engage in recreational drug use? ☐Daily ☐Weekly ☐Monthly ☐Rarely ☐Never
If yes, which ones? ☐Marijuana ☐Cocaine ☐PCP ☐Sniff glue/paint ☐Heroin ☐Amphetamines
☐Barbiturates ☐LSD ☐Other(s): _____
When did you last use a drug? _____ Age you first used a drug? _____

**Section 11: Family History** (Answer any statement that applies):
Check all that best describes your childhood family experience/home environment:
☐Outstanding ☐Normal ☐Chaotic ☐Witnessed _____ abuse ☐Experienced _____ abuse
My father ☐is living ☐died when I was_____ Describe relationship: _____
My mother ☐is living ☐died when I was_____ Describe relationship: _____
My parents separated or divorced when I was age _____
☐I was raised by both parents
How many siblings do you have? _____ Siblings ages? _____ How do you get along? _____

Where were you born? _____

**Section 12: Social History** (significant relationships, social support, nature/quality of relationships, etc.):
List who lives with you in your home? _____
*Living situation?* ☐Independent ☐Dependent on others ☐Dangerous ☐Overcrowded ☐Homeless ☐Other
*Financial situation*? ☐No problems ☐Large indebtedness ☐Poverty level or below ☐Impulsive spending ☐Relationship conflicts over finances
*Social support system*? ☐Supportive network of friends/family ☐Few friends ☐No friends ☐Substance abuse friends ☐ I live far from family ☐Estranged from family

**Section 13: Developmental History**
☐No known developmental delays- *continue to Section 14*
Or please list any diagnosed or known delayed developmental milestones (Development of Cognitive, Social/Emotional, Speech & Language, or Fine/Gross Motor Skills, etc.):
_____

**Section 14: Educational History**
☐Currently attending School ☐Full time student ☐Part time student
Name of College/Trade School/or Program: _____
Educational degrees completed: ☐HS Diploma ☐GED ☐Associates ☐Bachelors ☐Masters ☐Doctoral ☐Graduated, year _____
Were you in special education classes? ☐No ☐Yes, please describe: _____
What was your average grade in high school? ☐A ☐B ☐C ☐D ☐F

**Section 15: Occupational History** (answer any that apply)
Currently working ☐Full-time ☐Part-time ☐Unemployed ☐Homemaker/Caregiver
If yes, who is your employer? _____What is your position? _____
How long have you worked in your current job? _____
Do you enjoy working in your current position? ☐Yes ☐No
Are you satisfied in your current position? ☐Yes ☐No
Does your work make you stressed? ☐Yes ☐No
If yes, what are your work-related stressors? _____
What types of work have you done (i.e., labor, cashiering, healthcare, teaching, construction, management, etc.)?
_____
What was the longest time you stayed at a job? _____
What did you do at your last job? _____
When did you last work? _____
Why did your last job end? _____

**Section 16: Legal History**
Do you have a history of, or current legal problems? ☐No – *continue to Section 17.* ☐Yes
If yes, what crimes have you been charged with?
_____ _____
How many times have you been arrested or charged with a crime? None
How old were you the first time you were in trouble with the law? _____
When were you last charged with a crime? _____
Have you ever been in jail or prison? _____ How many times? _____

**Section 17: Other Information**
Goals (What I would like to accomplish in Therapy): _____
List your strengths/what you like about yourself _____
List challenges or obstacles that you feel stop you from succeeding _____
List areas you feel you would like to develop additional skills to manage or cope with symptoms better?
_____
I would describe myself as a ☐positive (optimistic) person ☐negative (pessimistic) person

What are some ways you cope with obstacles and stress? _____

**Current Symptoms -** Please check any of the following that apply to you:

- ☐ I experience excessive worry when there is no specific threat or actual risk present.
- ☐ I experience anxiety and worry about a variety of topics, events, or activities.
- ☐ My excessive worry occurs more days than not, and for at least 6 months.
- ☐ My worry is experienced as very difficult to control.
- ☐ I feel edgy or restless.
- ☐ I talk too fast/too much
- ☐ Panic attacks
- ☐ Phobias/fears: _____
- ☐ Repetitive thoughts or behaviors
- ☐ Compulsions
- ☐ I am tiring easily or more fatigued than usual.
- ☐ I feel as though my mind goes blank.
- ☐ Irritability (which may or may not be observable to others).
- ☐ Increased muscle aches or soreness.
- ☐ Difficulty sleeping (trouble falling asleep, staying asleep, restlessness at night, or unsatisfying sleep).
- ☐ My mood is depressed (often feeling very sad).
- ☐ I feel Depressed most of the day, nearly every day, and others tell me they notice it too.
- ☐ I feel "sad" or "empty".
- ☐ I cry frequently.
- ☐ I have decreased Interest or Pleasure in things I once enjoyed.
- ☐ I am easily agitated.
- ☐ I have a Loss of energy/Fatigue
- ☐ I have Feelings of Worthlessness or Guilt
- ☐ I have difficulty concentrating
- ☐ I have difficulty making decisions
- ☐ Feelings of hopelessness or helplessness
- ☐ I have recurrent thoughts of death
- ☐ Anxiety (often feeling very nervous)
- ☐ Hallucinations (hearing voices or seeing things that others don't)
- ☐ I can't get along with other people
- ☐ My behaviors can be aggressive or violent
- ☐ Drink too much alcohol
- ☐ Use illicit drugs (marijuana, heroin, cocaine, etc.)
- ☐ Memory problems
- ☐ Parenting/Family problems
- ☐ I exercise at least 2-3 times per week
- ☐ Have changes or difficulties with my eating habits
- ☐ I have had a weight change (lost or gained) in the last two months
- ☐ I have been treated for an Eating Disorder
- ☐ I have restricted my food intake or done bingeing or purging
- ☐ Impulsiveness
- ☐ Pornography use or sexual addiction problems
- ☐ I feel disconnected and/or numb
- ☐ Mood swings
- ☐ Homicidal thoughts
- ☐ Trouble planning
- ☐ Experience loss of time
- ☐ Other: _____