

Demographic Information

Name: _____ Date: _____

DOB: _____ Age: _____ Sex: Male Female

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number(s): _____ Is it ok to leave a voicemail? YES NO

Email: _____ Would you like to receive email communication? YES NO

Is it ok to send something in the mail? YES NO

How were you introduced to us? _____

If you found us online what words did you search to find us? _____

* Please complete below for additional client

Name: _____

DOB: _____ Age: _____ Sex: Male Female

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number(s): _____ Is it ok to leave a voicemail? YES NO

Email: _____ Would you like to receive email communication? YES NO

Is it ok to send something in the mail? YES NO

EMERGENCY CONTACT:

In case of an emergency who should we contact? (full name, relationship & phone number)

I agree to allow BettyJo Camp, LMHC to contact my emergency contact on my behalf in the case of emergency

Signature _____ Date _____

How Have We Come to Meet?

What are the 3 biggest concerns you have right now? How long have each been going on? Put them in order of importance:

- 1. _____
- 2. _____
- 3. _____

What solutions (helpful or unhelpful) have you tried to resolve the above concerns?

Have you had therapy in the past? If so, with whom and when? What reasons did you attend therapy for? Please share with us about your experience. What was helpful? Unhelpful?

Change is Coming...

What are your expectations from therapy? What are your expectations of the therapist?

What other things would you like to see change in your life (family, career, health, relationships, etc.)?

Do you foresee any obstacles to achieving your goals or the desired changes?

How long do you think therapy will need to last to achieve your goals? Write down a target date:

List strengths about yourself or that others say about you, give examples of each:

Is there anyone that you would like to be a part of your sessions or think may be helpful to be part of sessions either now or in the future? _____

Medical & Wellness Information

What do you do for wellness (i.e. healthy food choices, exercise, limits on TV/electronics/work, managing stress, family time, leisure, etc.)? Give examples of each:

Have you ever received psychiatric services before? YES NO
If yes, how long ago, with whom, for what, medications prescribed and results:

Do you have any allergies? (food, environmental, medicinal, animal, etc.)

Do you have any current or past medical issues, hospitalizations, accidents, injuries or surgeries? If yes, what?

Is there a family history of the above medical issues/concerns?

Are you presently under a physician's/psychiatrist's care? If so, for what reason?

In the past year, have there been any changes in your life? (i.e.: moves, appetite, sleep, health, family, overall functioning)?

List any medications (over-the -counter & prescribed), nutritional or herbal supplements, or alternative treatments (acupuncture, chiropractic, etc.) you are taking/doing and the reasons:

Important Questions We Must Ask

Have you ever had suicidal ideations? YES NO
If yes, please explain:

Do you currently have suicidal ideations? YES NO
If yes, please explain:

Have you ever planned or attempted to hurt yourself? YES NO

If yes, please explain:

Do you currently have a plan to hurt yourself? YES NO

If yes, please explain:

Have you ever felt like you wanted to seriously hurt or harm someone else? YES NO

If yes, please explain: _____

Do you currently feel like seriously hurting or harming someone else? YES NO

If yes, please explain: _____

Do you have weapons in your home or access to weapons? YES NO

If yes, who has access to them and what are the safety protocols around them?

Is there any history, past, or present abuse or violence? YES NO

If so, please explain: _____

Are you currently using any illegal drugs, or prescription medications in a way other than was prescribed, or is the reason you are seeking therapy services substance related?

Have you ever witnessed or experienced a trauma? Do you have reoccurring nightmares, flashbacks, or do you avoid anything that is uncomfortable or painful? If so, please explain:

Do you have currently legal issues or is the reason you are seeking therapy related to a court order? If so, please explain?

Career/Job, Recreation and Leisure

What is your current occupation? How would you describe your fulfillment of your job/career?

Highest level of education completed? Grade school High school College Vocational/Technical

GED Other: _____

What do you enjoy doing during your free/leisure time?

Intimate Relationships

If you are currently in a relationship, describe your relationship:

How would you describe your communication?

How would you describe intimacy in your relationship?

* If you are in a relationship answer the following regarding your relationship:

- 1. Like _____
- 2. Dislike _____
- 3. Not enough of _____
- 4. Too much of _____
- 5. Ideal relationship _____

Family History

Parent's marital status:

Married Divorced Never Married Separated Domestic Partners Widowed

Please describe your relationship with your parents:

How would you describe your upbringing?

Who do you currently live with? _____

Do you have any pets? If yes, names, types and relationship to each pet: _____

Describe your relationship with the following:

Mother: _____

Father: _____

Mother's Significant Other: _____

Father's Significant Other: _____

Siblings: Name, Age, and Sex: _____

Children: _____

Significant Other/Spouse: _____

Social Relationships

Describe your relationship with your friends: _____

Who would you say your support system is (people, organizations, or affiliations)?

Do you belong to any religious or spiritual groups? YES NO If yes, level of involvement?

How do your religious or spiritual beliefs/practices influence your life? _____

Please list anything else that is important for us to know about you that would assist us in working with you to achieve your desired results: _____