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Please provide the following information for my records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy.

Please bring this form to your first session.

Name:_____
(Last) (First) (M.I.)

Name of parent/guardian (If you are a minor):

_____
(Last) (First) (M.I.)

Birth Date: _____ Age: _____ Gender: Male / Female

Marital Status: _____

Number of children: _____

Local Address: _____
(Number & Street)

_____
(City) (State) (Zip)

Home Phone: _____ May I leave a message? _____

Cell Phone: _____ May I leave a message? _____

Email: _____ May I email you? _____
(Please note email might not always be confidential)

Referred by: _____

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? _____

Have you had previous psychotherapy or counseling? _____

Previous therapist's name _____

Are you currently taking prescribed psychiatric medication (antidepressants or others)? _____

If you are taking psychiatric medication please list them: _____

_____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (Please circle)

Poor Unsatisfactory Satisfactory Good Very Good

2. Are you having problems with your sleep habits? _____ If yes, please circle where applicable :

Sleeping too little Sleeping too much Poor quality sleep Disturbing dreams Other

3. How many times a week do you exercise? _____
Approximately how long each time? _____

4. Are you having any difficulty with appetite or eating habits? _____ If yes, circle where applicable:

Eating less Eating more Binging Restricting

Have you experienced significant weight change in the last two months? _____

5. Do you regularly use alcohol? _____
In a typical month how often do you have 4 or more drinks in a 24 hour period? _____

6. How often do engage in recreational drug use? (Please circle)

Daily Weekly Monthly Rarely Never

7. Have you had suicidal thoughts recently? (Please circle)

Frequently Sometimes Rarely Never

Have you had suicidal thoughts in the past? (Please circle)

Frequently Sometimes Rarely Never

8. Are you currently in a romantic relationship? _____

8. If yes, how long have you been in this relationship? _____
On a scale of 1-10, how would you rate the quality of your current relationship? _____

9. In the past year, have you experienced any significant life changes or stressors?

_____

_____

Have you experienced: (Please circle)

Extreme depressed mood

Wild mood swings

Rapid speech

Extreme anxiety

Panic attacks

Phobias

Sleep disturbances

Hallucinations

Unexplained losses of time

Unexplained memory lapses

Alcohol/substance abuse

Frequent body complaints

Eating disorders

Body image disorder

Repetitive thoughts (i.e. obsessions)

Repetitive behaviors (i.e. frequent checking, hand-washing)

Homicidal thoughts

Suicide attempt

FAMILY PHYSICIAN:

Do you currently have a general practitioner/physician? _____

If yes, who is your current physician? _____

If no, when was the last time you saw a general practitioner? _____

If necessary, may I contact your physician with your consent? _____

OCCUPATIONAL INFORMATION:

Are you currently employed? _____

If yes, who is your employer and what is your position? _____

_____

If yes, are you happy at your current position? _____

Please list any work-related stressors, if any: _____

_____

RELIFIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? _____

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? _____

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Circle those that apply and list family member, i.e., sibling, parent, etc.):

Difficulty	**Family Member**
Depression	_____
Bipolar Disorder	_____
Anxiety Disorder	_____
Panic Attacks	_____
Schizophrenia	_____

Alcohol/Substance Abuse _____

Eating Disorders _____

Learning Disabilities _____

Trauma History _____

Suicide Attempts _____

OTHER INFORMATION:

What do you consider to be your strengths? _____

_____

_____

_____

What do you like most about yourself? _____

_____

_____

_____

What are effective coping strategies that you've learned? _____

_____

_____

_____

What are your goals for therapy? _____

_____

_____

_____