Initial Visit Information

Please answer the following questions to the best of your ability. ***Please be as specific and detailed as possible.*** **If necessary, use the back of each page to continue your answers.**

Identifying Information:

Name: _____ Today's Date: _____
Gender: _____ Pronouns: _____
Date of Birth:_____ Age: _____ Marital Status: _____

Please indicate if any of the following are problematic for you at this time:

___Sadness/depression
___Anxiety/panic
___Relationship issues
___Concerns about your eating
___Other_____
___Sleep problems
___Obsessive thoughts
___Suicidal thoughts
___Significant life changes (i.e. job, divorce)

Behavioral Health History:

Please describe any current or past behavioral health treatment including inpatient hospitalizations and/or outpatient counseling:
Name of Provider: _____ Dates : _____
_____
_____
_____
Please list any medication you have ever taken for psychiatric reasons:_____
_____
Please describe any personal drug or alcohol use:_____
_____
Have drugs or alcohol ever been a problem for you? □ Yes □ No
Please describe any family history of psychiatric illness or substance abuse:_____
_____

Medical History:

Please list any recent or current medical problems and/or injuries: _____
_____
_____
Please list any operations, hospitalizations or significant procedures: _____
_____
_____
Please list all medications you are currently taking (continue on the back of this page if necessary):
_____
_____
_____

Primary Care Physician:

Name:_____
Address:_____
Phone:_____

Family History:

Mother*:* Living _____ Age now _____ Deceased (age at time)_____
Father*:* Living _____ Age now _____ Deceased (age at time) _____
Significant step parent(s) (please specify): _____
Living _____ Age now _____ Deceased (age at time) _____
Were your parents divorced? ☐ Yes ☐ No How old were you when they were divorced? ____
Do you have any siblings? ☐ Yes ☐ No Number of Sisters:_____ Brothers:_____
Are you married/living with a life partner? ☐ Yes ☐ No
Do you have any previous marriages? ☐ Yes ☐ No
Do you have any children? ☐ Yes ☐ No Number of Daughters:_____ Sons:_____
Do you feel safe at home? ☐ Yes ☐ No Are you afraid of anyone? ☐ Yes ☐ No

Social History:

Highest grade completed: _____
What kind of work do you do?_____
What do you do to cope with stress? _____
_____
Please list any significant life events that you are currently experiencing (i.e. divorce, job change, financial difficulties, etc.): _____
_____
Who in your life is supportive of you?_____
_____

Name any interests or hobbies that you have
_____
_____

What do you consider to be your strengths? -
_____
_____