General Demographic Information

Name _____Full Name

Date of Birth _____

Today's Date _____

Full Address _____

Phone_____ Email: _____

1. Have you previously received any type of mental health services? □ No □ Yes
2. If yes, which of the following:

   □ Psychotherapy □ Medication □ Outpatient Hospitalizations □ Inpatient Hospitalization

3. What significant life changes or stressful events have you experienced?

4. What would you like to accomplish out of your time in therapy?

5. How would you rate your current sleeping habits? (please circle)

   Poor Unsatisfactory Satisfactory Good Very good

6. How many times per week do you generally exercise? _____

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7. Please list any current medications/supplements below.

Medication/Supplement	Condition