Sunny M. Mueller, LPCC

661.563.0638
SUNNYMMUELLER.LPCC@OUTLOOK.COM
WWW.SUNNYMMUELLER.COM
CALIFORNIA LPCC#610

Demographic - ADULT

I am excited that you have chosen to start your mental health wellness journey! I want to make the most of each appointment you have. One way of doing this is for you to write down some basic information in advance of your first appointment. Please fill out the following as completely and legibly as possible. The information you provide on this form is confidential and cannot be released to anyone without your explicit written consent. If you have concerns about the relevance of any information requested and wish to leave it out, please feel free to do so.

I. Demographic

Last Name | First Name | Date of Birth

Street/Mailing Address | Email Address

City | State | Zip

Phone #1
Contact at this number? ☐ Yes ☐ No
Message at this number? ☐ Yes ☐ No

Phone #2
Contact at this number? ☐ Yes ☐ No
Message at this number? ☐ Yes ☐ No

☐ Male ☐ Female ☐ Transgender ☐ Other: _____ ☐ Decline to State

Birthplace | Ethnicity | Primary Language

Relationship Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Spouse/Partner's First Name: _____ Length of Relationship: _____

Do you have any children? ☐ Yes ☐ No
If yes, please provide the following:

_____ Live with you? ☐ Yes ☐ No
Name | Age | Gender

_____ Live with you? ☐ Yes ☐ No
Name | Age | Gender

_____ Live with you? ☐ Yes ☐ No
Name | Age | Gender

Highest Education Achieved: ☐ HS/GED ☐ AA/AS ☐ BA/BS ☐ MA/MS ☐ Doctorate ☐ Other: _____

Are you active military or a veteran? ☐ Yes, Active ☐ Yes, Veteran Branch: _____ ☐ No

Referred by? _____

II. General Health Information

Do any of the following apply to you?

A. *History* of… If checked, please explain…

☐ Use of tobacco products _____
☐ Use of alcohol _____
☐ Use of illicit substances _____
☐ Misuse of prescription drugs _____
☐ Use of caffeine _____
☐ Exercise on a regular basis _____

B. *Current*… If checked, please explain…

☐ Use of tobacco products _____
☐ Use of alcohol _____
☐ Use of illicit substances _____
☐ Misuse of prescription drugs _____
☐ Use of caffeine _____
☐ Exercise on a regular basis _____

What else should I know about your general health?

III. Emergency Contact

Last Name First Name

Address

City State Zip

Phone #1 Phone #2

Relationship to client

IV. Employment History

Current Occupation: _____

Employment Status: ☐ Currently Working ☐ Unemployed ☐ Disabled ☐ Workers Comp ☐ Retired

What else should I know about your employment history?

V. Medical History

Primary Care Physician (*current*) ☐ Not Applicable

Last Name First Name

Address

City State Zip

Phone Fax

A. Are you *currently* under the care of a medical specialist? ☐ Yes ☐ No

If yes, please explain type of specialist: _____

B. Have you *ever* been under the care of a medical specialist? ☐ Yes ☐ No

If yes, please explain when and type of specialist: _____

C. Please list any *chronic illnesses*, *disabilities*, *and/or medical conditions* that you have been professionally diagnosed with: ☐ Not Applicable

Illness/Disability/Medical Condition Date Diagnosed

Illness/Disability/Medical Condition Date Diagnosed

Illness/Disability/Medical Condition Date Diagnosed

D. Please list any medications, prescription and over-the-counter, you *currently* take for any chronic illnesses, disabilities, and/or medical conditions. Include the name of the medication, what the medication is treating, the dosage (mg), and how often the medication is taken. ☐ Not Applicable

Medication Condition Dosage (mg) per d/w/m

Medication Condition Dosage (mg) per d/w/m

Medication Condition Dosage (mg) per d/w/m

When was your most recent physical/check-up? _____ ☐ Not Applicable

What else should I know about your medical history?

VI. Mental Health History

Psychiatrist (*current*) ☐ Not Applicable

Last Name First Name

Address

City State Zip

Phone Fax

Psychologist, Therapist, or Counselor (*current*) ☐ Not Applicable

Last Name First Name

Address

City State Zip

Phone Fax

A. Have you *ever* been under the care of a psychiatrist? ☐ Yes ☐ No
If yes, please explain:

Dates	Psychiatrist	Circumstances
Dates	Psychiatrist	Circumstances
Dates	Psychiatrist	Circumstances

B. Have you *ever* received therapy and/or counseling? ☐ Yes ☐ No
If yes, please explain:

Dates	Therapist/Counselor	Circumstances
Dates	Therapist/Counselor	Circumstances
Dates	Therapist/Counselor	Circumstances

C. Have you *ever* been admitted to a psychiatric hospital? ☐ Yes ☐ No
If yes, please explain:

Dates	Hospital	Circumstances
Dates	Hospital	Circumstances
Dates	Hospital	Circumstances

D. Please list any *mental health conditions* that you have been professionally diagnosed with: ☐ Not Applicable

Mental Health Condition	Date Diagnosed
Mental Health Condition	Date Diagnosed
Mental Health Condition	Date Diagnosed

E. Please list any medications, prescription and over-the-counter, you *currently* take for any mental health conditions. Include the name of the medication, what the medication is treating, the dosage (mg), and how often the medication is taken. ☐ Not Applicable

Medication	Condition	Dosage (mg) per d/w/m
Medication	Condition	Dosage (mg) per d/w/m
Medication	Condition	Dosage (mg) per d/w/m

What else should I know about your mental health history?

VII. Trauma History

Check the box next to the events you have witnessed and/or experienced, *currently and/or in the past*.

☐ Not Applicable

☐ Natural disaster
☐ Human-made disaster
☐ Serious accident/injury
☐ Chemical or radiation exposure
☐ Life-threatening illness
☐ Death of close friend
☐ Death of family member
☐ Kidnapping
☐ Hostage situation
☐ Terrorist attack
☐ Torture
☐ War
☐ Dead bodies (not at a funeral)
☐ Attack with a weapon
☐ Injury from hitting, spanking, choking, pushing
☐ Forced, unwanted sexual contact
☐ Other: _____
☐ Other: _____

Please explain:

What else should I know about your trauma history?

VIII. Crisis History

A. Are you *currently* having thoughts of wanting or intending to…

☐ No YES: ☐ kill yourself?
☐ die?
☐ seriously harm yourself (without the intent to die)?

If yes to any, please explain: _____

B. Are you *currently* having thoughts of wanting or intending…

☐ No YES: ☐ to kill someone else?
☐ someone else to die?
☐ to seriously harm someone else (without the intent of death)?

If yes to any, please explain: _____

C. Have you *ever* had thoughts of wanting or intending to…

☐ No YES: ☐ kill yourself?
☐ die?
☐ seriously harm yourself (without the intent to die)?

If yes to any, please explain: _____

D. Have you *ever* attempted to kill yourself? ☐ Yes ☐ No
If yes, please explain:

Date	Circumstances	Result *(Hospitalization, therapy, etc.)*
Date	Circumstances	Result *(Hospitalization, therapy, etc.)*
Date	Circumstances	Result *(Hospitalization, therapy, etc.)*

E. Have you *ever* seriously harmed yourself (without the intent to die)? ☐ Yes ☐ No
If yes, please explain:

Date	Circumstances	Result *(Hospitalization, therapy, etc.)*
Date	Circumstances	Result *(Hospitalization, therapy, etc.)*
Date	Circumstances	Result *(Hospitalization, therapy, etc.)*

F. Have you *ever* seriously harmed someone else, with or without the intent of death? ☐ Yes ☐ No
If yes, please explain:

Date	Circumstances	Result *(Hospitalization, therapy, etc.)*
Date	Circumstances	Result *(Hospitalization, therapy, etc.)*
Date	Circumstances	Result *(Hospitalization, therapy, etc.)*

What else should I know about your crisis history?

IX. Family History

A. Biological Mother ☐ Deceased ☐ Incarcerated ☐ Unknown ☐ Other: _____

Last Name First Name

Occupation

B. Biological Father ☐ Deceased ☐ Incarcerated ☐ Unknown ☐ Other: _____

Last Name First Name

Occupation

C. Biological parents are: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

D. Do you have any siblings? ☐ Yes ☐ No
If yes, please provide the following:

Name	Age	Gender	Bio/Step/Adopted/Other	Residence
Name	Age	Gender	Bio/Step/Adopted/Other	Residence
Name	Age	Gender	Bio/Step/Adopted/Other	Residence

E. Is there a history of *diagnosed/undiagnosed mental illness* in your family? ☐ Yes ☐ No
If yes, please give the relationship of the relative to you and the mental illness (if known).

Relationship: ☐ Maternal ☐ Paternal ☐ Unknown Mental Illness: ☐ Diagnosed ☐ Undiagnosed

Relationship: ☐ Maternal ☐ Paternal ☐ Unknown Mental Illness: ☐ Diagnosed ☐ Undiagnosed

F. Is there a history of *diagnosed/undiagnosed substance use disorder/addiction* in your family? ☐ Yes ☐ No
If yes, please give the relationship of the relative to you and the substance/addiction (if known).

Relationship: ☐ Maternal ☐ Paternal ☐ Unknown Substance/Addiction: ☐ Diagnosed ☐ Undiagnosed

Relationship: ☐ Maternal ☐ Paternal ☐ Unknown Substance/Addiction: ☐ Diagnosed ☐ Undiagnosed

What else should I know about your family history?

X. Symptoms

A. What symptoms do you have and how long have they been active? ☐ Not Applicable

B. Do these symptoms affect your activities of daily living? ☐ Yes ☐ No
If yes, which ones?

☐ Independent Living Tasks (providing yourself with food, shelter, clothing, and basic living essentials)
☐ Social/Community Relationships (engaging in meaningful activities, connecting with others)
☐ Vocational/Educational Responsibilities (accomplishing work and/or school demands and requirements)
☐ Physical Care Routines (making and attending medical/mental health appointments, self-care)

XI. Strengths and Goals

A. What are your *strengths*? What do people like about you? What do YOU like about you?

B. How would you describe your *self-esteem*?

C. What are your current coping skills? What helps you function now?

D. What meaningful activities do you participate in and how often?

E. What are your cultural, spiritual, or religious beliefs, if any?

F. Why have you sought mental health services today?

G. In your own words, what is the nature of the concern that you wish you to address in therapy?

H. What are your *goals* for therapy? What do you want to accomplish?

What else should I know about you?

I attest I am the person whose name appears on the first page and all information provided is accurate and true.

Client Name (PRINT)

Client (SIGN) DATE