

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 Phone #2
Contact at this number? N Y Contact at this number? N Y
Message at this number? N Y Message at this number? N Y

A. Male Female Transgender Other: _____ Decline to State

B. Birthplace: _____ Ethnicity: _____

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

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

E. Referred by? _____

II. Emergency Contact

Last Name First Name

Address

City State Zip

Phone #1 Phone #2

Relationship to client

A. Are you currently under the care of a medical specialist? N Y *If yes, please explain:*

B. Have you ever been under the care of a medical specialist? N Y *If yes, please explain:*

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
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Illness/Disability/Medical Condition	Date Diagnosed
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Illness/Disability/Medical Condition	Date Diagnosed
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D. Please list any medications, prescription and over the counter, you currently take for any chronic illnesses, disabilities, and/or medical conditions. Not Applicable

Medication	Condition	Dosage (mg)
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Medication	Condition	Dosage (mg)
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Medication	Condition	Dosage (mg)
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E. When was your most recent physical/check-up? _____ Not Applicable

What else should I know about your medical history? _____

VI. Mental Health History

A. Psychiatrist (*current*) Not Applicable

Last Name	First Name
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Address

City	State	Zip
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Phone	Fax
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B. Psychologist, Therapist, or Counselor (*current*) Not Applicable

Last Name	First Name
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Address

City	State	Zip
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Phone	Fax
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C. Have you ever been under the care of a psychiatrist? N Y *If yes, please explain:*

Dates	Psychiatrist	Circumstances
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Dates	Psychiatrist	Circumstances
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Dates	Psychiatrist	Circumstances
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D. Have you ever received therapy and/or counseling? N Y *If yes, please explain:*

Dates	Therapist/Counselor	Circumstances
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Dates	Therapist/Counselor	Circumstances
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Dates	Therapist/Counselor	Circumstances
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E. Have you ever been admitted to a psychiatric hospital? N Y *If yes, please explain:*

Dates	Hospital	Circumstances
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Dates	Hospital	Circumstances
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Dates	Hospital	Circumstances
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F. Please list any *mental health conditions* that you have been professionally diagnosed with:

Not Applicable

Mental Health Condition	Date Diagnosed
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Mental Health Condition	Date Diagnosed
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Mental Health Condition	Date Diagnosed
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G. Please list any medications, prescription and over the counter, you currently take for any mental health conditions. Not Applicable

Medication	Condition	Dosage (mg)
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Medication	Condition	Dosage (mg)
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Medication	Condition	Dosage (mg)
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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

	Yes	If yes, please explain:
Natural disaster		
Human-made disaster		
Serious accident/injury		
Chemical or radiation exposure		
Life-threatening illness		
Death of a close friend, family member, or co-worker		
Suicide of a close friend, family member, or co-worker		
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:		
Other:		

What else should I know about your trauma history? _____

VIII. Crisis/Suicide 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: _____

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. 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 of this document and all information provided herein is accurate and true.

Client Name (PRINT)

Client (SIGN)

DATE