

Mindy Maxwell Clinical Services, PLLC
Mindy Maxwell, MHP, LMHC

Basic information:

Name: _____

Mailing address: _____

Date of Birth: _____

Gender: _____

Home phone number: () - _____ Ok to leave message? _____

Cell phone number: () - _____ Ok to leave message? _____

Email address: _____

**Please be aware that email may not be a confidential form of communication.

Emergency Contact Information:

In case of emergency, who should I contact?

Name: _____

Phone number: _____

Relationship: _____

Who referred you to my office or how did you learn about my practice? _____

Areas of concern that brings you to therapy? When did this start happening/why do you think it is happening? _____

Are you currently experiencing any of the following symptoms? (please circle)

Anxiety	Depression	Memory difficulties
Panic	Loss of interest in activities	Anger
Loss of appetite	Agitation	Helplessness/hopelessness
Dizziness	Too little/much sleep	Procrastination
Compulsive action	Hearing things others don't	Confusion
Social withdrawal	Loneliness	Seeing things others don't
Obsessive behaviors	Lack of concentration	Fatigue

Sadness Trouble initiating activities Increase in disorganization
Grief Outbursts Excessive energy
Nightmares Impulsiveness Thoughts that scare you

What have you been doing to address these concerns? What makes you feel better?____

If you had a magic wand and could make everything better, what would you see? ____

How hopeful are you that you can improve on or resolve these issues on a scale of 1-10. (0=not possible, 10=completely possible)? _____

Previous Treatment:

Have you received or participated in previous behavioral health counseling and/or therapy?

Yes No

What have your previous diagnosis(es) been? _____

If yes, what was helpful at the time? What wasn't? _____

Have you ever been hospitalized for a behavioral health condition? _____

Do you have an Advanced Directive? Yes No

Medical History:

List any current medications: _____

Other health concerns, allergies, serious illnesses, conditions, or major operations requiring hospitalization during your lifetime: _____

Do you have a primary care physician and get regular check-ups?

Yes No

What is the name and phone number of your PCP? _____

Describe your current health Excellent Good Ok Poor

Family of Origin History:

Raised by: _____

Siblings: Yes No

Relationship with family (good, poor, fair, close, distant): _____

Any history of neglect, and/or physical, verbal, emotional, spiritual or sexual abuse?

Yes No

Any history of substance abuse, behavioral health, suicide or violence?

Yes No

Any additional family information: _____

What best describes your relationship status? _____

If you are in a relationship, what best describes your satisfaction with the relationship: _____

Do you have children?

Yes No

Social History:

Describe your relationship with peers and/or friends: _____

How would you describe your social support network? _____

Describe your hobbies/interests: _____

What ethnicity(s) do you identify with? How does your culture/ethnicity play a role in your life? _____

Describe your religious/spiritual beliefs? _____

Are you or your parent(s) an immigrant or a refugee? _____

Educational & Work History:

What is the highest educational level you have completed? _____

What is your current job and are you satisfied? _____

Are you experiencing work stressors or transitions? _____

Substance Use History:

If you drink alcohol, how often do you drink? _____

How many drinks in one sitting? _____

If you use recreational drugs, what type and how often? _____

Have you had any inpatient or outpatient treatment for drugs or alcohol? _____
Has anyone ever suggested you go? _____
Do you think drugs or alcohol plays a part in your current concerns? _____

Legal History:

Have you ever been a victim of a crime? _____

Risk Assessment:

Are you now thinking of or have you ever harmed yourself? _____

Do you remember a time when you threatened to hurt or kill yourself, cut on yourself? _____

Are you now thinking of or have you ever harmed another person?

Thoughts/Ideation Plan Recent attempt History Precipitating events: _____

Current Risk: SI None Low Medium High
HI None Low Medium High

Reason for Risk Level:

Safety Contract signed: N/A Yes No. If no, state why if risk present: _____

Now for the good stuff!

Summarize your goals for counseling/therapy: _____

What expectations do you have for counseling/therapy? _____

Name 5 things you feel would make your life more enjoyable and authentic:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

What are your strengths: _____

Is there any additional information you believe it is important for me to know in order to provide you with the best care possible? _____

Do you need a referral for:

- Doctor/Dentist
- Psychiatric Services
- Other: _____
- Drug/Alcohol Evaluation
- Anger Management Program

Signature of client or guardian

Date

Signature of therapist

Date