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? Is there something specific, such as particular event? Be as detailed as you can. _____

_____

_____

_____

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
		Have beliefs that other don't

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
If yes, what was helpful at the time? What wasn't?_____
_____
What have your previous diagnosis(ses) been?_____
_____
Have you ever been hospitalized for a behavioral health condition? _____
_____
Do you have a Psychiatric Advanced Directive? ☐ Yes ☐ No

Medical History:

Describe your current health ☐ Excellent ☐ Good ☐ Ok ☐ Poor
Other health concerns, allergies, serious illnesses, conditions, or major operations requiring hospitalization during your lifetime: _____
_____
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? _____
_____
Have you ever tested positive for COVID-19?_____
If so, do you have any long-term or chronic COVID symptoms?_____
_____

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 present or history of traumatic experiences?_____
_____
Any history of familial substance abuse, behavioral health, suicide or violence?
[ ] Yes [ ] No
In school were you diagnosed with developmental delays or disabilities? Were you on an IEP or 504 plan?_____
Any additional family information: _____
_____
_____
What best describes your relationship status? How is your level of satisfaction with the relationship? _____
_____
If you are in a relationship, what best describes your satisfaction with the relationship:_
_____
Do you have children?
[ ] Yes [ ] No
Names, gender identity and ages:_____
_____
Any additional relevant family information_____
_____

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? How long have you been doing it?_____

_____

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 outpatient or inpatient 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:

Do you have current self-harm/injury thoughts or urges?_____

_____

_____

Do you have past self-harm/injury thoughts or urges?_____

_____

_____

Do you have current suicide thoughts or urges?_____

_____

_____

Do you have past suicide thoughts or urges?_____

_____

_____

Do you have current thoughts or urges to harm others?_____

_____

_____

Do you have past thoughts or urges to harm others?_____

_____

_____

☐ 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: _____

_____

_____

How will you know you are ready to end therapy?_____

_____

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 ☐ Drug/Alcohol Evaluation
☐ Psychiatric Services ☐ Anger Management Program
☐ Other: _____

_____ _____
Signature of client or guardian Date

_____ _____
Signature of therapist Date