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 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
What have your previous diagnosis(ses) 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

Names and Ages:_____

_____

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

_____ _____
Signature of client or guardian Date

_____ _____
Signature of therapist Date