**Alisha L. Wagner, Ph.D., PLLC**

**6750 West Loop South, Suite 725**

 **Bellaire, Texas 77401**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: ❑ Female ❑ Male Date of birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Okay to leave a message? ❑Yes ❑ No Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact (Name & number):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your relationship to emergency contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the main reason or concern that lead you to seek therapy at this time? (describe briefly): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**RELATIONSHIP STATUS:**

❑ Single ❑ Engaged ❑ Married (how long? \_\_\_\_\_\_\_\_) ❑ Separated (how long? \_\_\_\_\_\_\_\_)

❑ Divorced (how long? \_\_\_\_\_\_\_) ❑ Widowed (how long? \_\_\_\_\_\_\_\_)

**EDUCATION:**

How far did you get in school?

 ❑ High School ❑ Some college ❑ College degree ❑ Master's ❑ Doctorate ❑ Other

Area of study:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any special circumstances? (learning disabilities, dyslexia, ADHD, fighting in school, gifted/talented, etc.):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**EMPLOYMENT**

Are you currently employed? ❑ Yes ❑No

If Yes, what is your job title or description?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you held this job?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the longest job you’ve had?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been let go or fired from a job? ❑Yes ❑No

If Yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**MILITARY SERVICE**

Military Service? ❑Yes ❑ No

If Yes, when, where, what branch, etc.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Relationship** |  **Name**  | **Age** | **Living?** | **Living with you?** |
| Mother |  |  | ❑Yes ❑No  |  ❑Yes ❑No  |
| Father |  |  | ❑Yes ❑No  |  ❑Yes ❑No  |
| Brothers/Sisters |  |  | ❑Yes ❑No  |  ❑Yes ❑No  |
| Spouse/Partner |  |  | ❑Yes ❑No  |  ❑Yes ❑No  |
| Children |  |  | ❑Yes ❑No  |  ❑Yes ❑No  |

**DEVELOPMENTMENTAL**

Any problems at birth, defects, developmental problems or delays? ❑ Yes ❑ No

If Yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any special, unusual, or traumatic circumstances that affected your development or upbringing? ❑Poverty ❑Malnutrition ❑Abuse ( \_\_sexual \_\_\_physical \_\_\_verbal)

❑Neglect ❑Domestic violence ❑Death of parent ❑Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SPIRITUAL INFORMATION**

Are you affiliated with a religion or spiritual group? ❑ Yes ❑ No

If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you raised with a certain religious affiliation or spiritual group? ❑ Yes ❑ No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How important is your religion or spiritual group to you now?

❑ Not at all ❑A little ❑Moderately ❑A lot

**LEGAL**

Are you involved in any active legal cases (traffic, civil, criminal, family)? ❑Yes ❑ No

Are you currently on probation or parole? ❑Yes ❑No

If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been charged with a felony or misdemeanor (not including traffic violations)? ❑Yes ❑No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL/PHYSICAL HEALTH**

Please check if there have been any recent changes in the following:

❑Sleep patterns ❑Eating patterns ❑Behavior ❑Energy level

❑Physical activity level ❑Mood ❑Weight ❑Nervousness/anxiety

❑Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check any of the following that apply to you:**

|  |  |  |
| --- | --- | --- |
| ❑AIDS | ❑Eating problems | ❑Nausea  |
| ❑Alcohol abuse | ❑Epilepsy | ❑Neurological disorders |
| ❑Abdominal pain | ❑Fainting | ❑Nose bleeds |
| ❑Allergies | ❑Fatigue | ❑Sexually transmitted disease(s) |
| ❑Anemia | ❑Fertility issues | ❑Sleeping disorders |
| ❑Arthritis | ❑Frequent urination | ❑Sinusitis |
| ❑Asthma | ❑Headaches | ❑Stroke |
| ❑Cancer | ❑Hearing problems | ❑Sexual problems |
| ❑Chronic pain | ❑Hepatitis | ❑Tuberculosis (TB) |
| ❑Constipation | ❑High blood pressure | ❑Thyroid problems |
| ❑COPD | ❑Kidney problems | ❑Vision problems |
| ❑Dental problems | ❑Liver problems | ❑VomitingVV |
| ❑Diabetes | ❑Measles | ❑Other (specify): |
| ❑Diarrhea | ❑Menstrual pain | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| ❑Drug abuse | ❑Miscarriage(s) |  |
|  |   |  |

List prescription and over the counter medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**MENTAL HEALTH**

**Please check behaviors and symptoms that you have been experiencing:**

|  |  |  |
| --- | --- | --- |
| ❑Aggression | ❑Elevated mood | ❑Phobias/fears |
| ❑Alcohol abuse | ❑Fatigue | ❑Recurring thoughts |
| ❑Anger | ❑Gambling | ❑Sexual addiction |
| ❑Antisocial behavior | ❑Hallucinations | ❑Sexual difficulties |
| ❑Anxiety | ❑Heart palpitations | ❑Sick often |
| ❑Avoiding people | ❑High blood pressure | ❑Sleeping problems |
| ❑Chest pain | ❑Hopelessness | ❑Speech problems |
| ❑Cyber addiction | ❑Impulsivity | ❑Suicidal thoughts |
| ❑Depression | ❑Irritability | ❑Thoughts disorganized |
| ❑Disorientation | ❑Judgment errors | ❑Trembling |
| ❑Distractibility | ❑Loneliness | ❑Withdrawing |
| ❑Dizziness | ❑Memory problems | ❑Worrying |
| ❑Drug abuse | ❑Mood shifts | ❑Other (specify):  |
| ❑Eating problems | ❑Panic attacks |  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  |  |  |

**ALCOHOL USE**

Do you consume alcohol (beer, wine, mixed drinks, liquor, etc.)? ❑Yes ❑No

If yes, how often? How much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SUBSTANCE USE**

Do you currently use any drugs other than medications prescribed to you? ❑Yes ❑No

If yes, which ones?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often? (every day, every weekend, monthly, etc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At what age did you first start using drugs?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIOR MENTAL HEALTH SERVICES**

Have you ever seen a therapist or attended a therapy/self-help group before now? ❑Yes ❑No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How helpful was it and what was your experience like?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever been hospitalized for psychiatric problems? ❑Yes ❑No

If Yes, please provide date(s), name of hospital, and primary reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**THOUGHTS OF HARMING YOURSELF OR OTHERS**

Do you have thoughts of harming yourself or someone else? ❑Yes ❑No

If yes, please describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Is there anything else important about you that you’d like to add?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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