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Please fill out the entire form, answering the questions as they pertain to you. Leave blank any that are unclear or that you want additional clarification on. Thank you.

General Information

Name: ________________________________Nickname: ___________________Date of Birth: _____/_____/_____

Sex: Male _____ Female ______ SSN: ______________________ Today's date: _____/_____/_____

Home phone: (____) ________________ Cell: (____) ________________

Address:____________________________________ City: __________________ State: ___________ Zip: ____________

Employer: ___________________________Work phone: (_____) __________________ Email: _____________________

Address: ____________________________________ City: ___________________ State: ___________ Zip: ___________

Who will be responsible for making/keeping appointments? ____

Ok to leave phone message? Yes No Which number? _____________________________ Ok to send mail? Yes No

Emergency contact/Relation: ________________________ Phone: (____) ______________ Alt phone:(____)___________

Primary care provider: _________________________Clinic name/phone:__________________________________

Allergies: _______________________________ Medical conditions: ____

Interests/hobbies: ____

I was referred by: ____

Insurance Information

Insurance Provider: _________________Subscriber's name: _______________Subscriber's birthdate: _____/_____/_____

Name of employer: ______________________ Subscriber's address (if different than above): ________________________

Insurance phone: ____________________________ Address: ____

ID#: _________________________ Group #: ________________________

**A copy of your card will be made if you would like your insurance to be billed for reimbursement

Therapy Goals and History

What brings you in?

____

____

What would you like to be different?

____

____

Who supports you and your family in your decision to begin counseling? ______________________________

Have you seen a therapist before? Yes ____ No ____ When? __________From 1-10, rate previous experiences: _________

Name(s) of previous therapist(s): ______________________________________ Phone: (____) ______________________

____

What helped? ____ What didn't? ______________________________

Family History

Who lives in the home? Names, ages and relationship. ____

____

____

Who are the significant adult figures in your life?

____

Describe significant changes/transitions in your life and the age that they occurred. For example, divorce, moves, death/loss.

____

____

____

____

Symptom Checklist

Check 0, if you are not currently concerned about the symptom; 1, if it is a mild concern; 2, if it is a moderate concern and 3, if it is a serious concern.

Symptom	0	1	2	3	**Symptom**	0	1	2	3
Depression mood/sadness					Sleep trouble				
Grief and Loss					Fatigue/low energy				
Loss of appetite					Weight gain or loss				
Apathy or lack of motivation					Suicidal thoughts or attempts				
Substance Abuse					Feelings of worthlessness				
Headaches/Stomach pain					Social isolation				
Guilt/Shame					Poor attention or focus				
Hyperactivity					Self-esteem issues				
Mood swings					Unusual or racing thoughts				
Anger					Aggression/violence				

Anxiety or worry					Panic attacks				
Phobias					Obsessions				
Compulsive behavior					Victim of abuse or trauma				
Feeling detached or distant					Hearing or seeing things				
Self-harming or cutting					Difficulties keeping/making friends				
Exposure to domestic violence					Legal trouble				
Learning difficulties									
Poor grooming/hygiene					Irritability				
Bingeing/purging					Anorexia				
Tearfulness					Victim of a crime				
Defiance/oppositional behavior					Other:________________				
Nightmares					Other:________________				
Other:_________________					Other:________________				

Psychiatric Treatment History

Have you seen a psychiatrist in the past? Yes ____ No ____ Name/phone: ____

Are you currently seeing a psychiatrist? Yes ____ No ____ Name/phone: ____

Current medications and supplements, along with dosage: ____

____

____

Have you been hospitalized for emotional, psychological or substance use issues? Yes ___ No ___

If yes, when and for how long: ____

Location/Facility name: ____

Has anyone else in your family had similar psychological or emotional difficulties and/or concerns? Please explain.

____

____

____

____

Substance Use Inventory

Please indicate if you have used or are currently using the following substances. Please list other family members who have used or are currently using.

	Age of first use	When last used	Current frequency and amount	Previous treatment	Family members with past or

					current use issues
Alcohol				Yes No	
Marijuana/ Hashish				Yes No	
Meth/"Speed"				Yes No	
Cocaine/Crack				Yes No	
Heroin				Yes No	
Prescription drugs				Yes No	
Inhalants				Yes No	
Ecstasy/Molly				Yes No	
Mushrooms				Yes No	
Caffeine				Yes No	
Nicotine				Yes No	
Other:				Yes No	
Other:				Yes No	
Other:				Yes No	

Socioeconomic History:

Living Situation

Housing Adequate ❐
Homeless ❐
Housing overcrowded ❐
Housing dangerous/deteriorating ❐
Living companions unstable ❐

Family Financial Situation

No current financial stress ❐
Large debt ❐
Low income ❐
Impulse spending ❐
Relationship conflict over money ❐

Legal History

No legal problems ❐
Parole/probation ❐
Arrest(s) not substance related ❐
Arrest(s) substance related ❐
Jail/Prison time ❐

Employment

Employed and satisfied ❐
Employed but dissatisfied ❐
Unemployed ❐
Conflicts at work ❐
Unstable work history ❐
Disabled ❐
Student/underage ❐

Family's Social Support System

Supportive network of friends and family ❐
Few friends ❐
New to the area ❐
No friends ❐
Geographically or emotionally distant from family ❐

Cultural and Spiritual History

Cultural identity: ____Spiritual identity: ____________________________________

Importance of spirituality/religion: Low Med High

Is your family currently active in your community? ________If so, describe: ____

Does your family currently engage in spiritual activities? _____If so, describe:_______________________________________