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Patient Information

Date: ______________

Name: ______________________________________ DOB: ________________ Age: _______

Address: ____

City: ______________________________________ State: _________ Zip: ________________

Places you authorize me to leave a message, identify myself, and leave a return number:

Phone: __________________________________

Email: ____

Occupation: ____

Education: ____

Emergency Contact:

Name: ____ Relationship: ___________________

Phone: _____________________________________

Referral Information:

Who referred you? _______________________________ May I thank them? ___ Yes or ___ No

Signature for your consent: _________________________

List any children that you have, and also list those who live in your household, including non-family members.

Name	Age	Relationship to You	At Home?

Why are you seeking therapy at this time?

____

____

What are your goals for therapy?

____

____

____

Major life changes or losses in the last year? _______________________________

List any prescription medications you take, and the reason for taking:

____

____

Have you ever been to therapy before? If so, when and for how long?

____

____

Current Symptom Checklist: (check all that describe how you've been feeling)

- ☐ Sleep problems
- ☐ Not enjoying activities
- ☐ Problems at work
- ☐ Obsessive thoughts
- ☐ Lack of friends
- ☐ Shy, uncomfortable around others
- ☐ Racing thoughts
- ☐ Eating problems
- ☐ Compulsive behaviors
- ☐ Wanting to hurt yourself
- ☐ Wanting to harm others
- ☐ Aggressive or abusive
- ☐ Easily angered or angry a lot
- ☐ Problems with decision making
- ☐ Abused by others
- ☐ Impulsive
- ☐ Weight concerns
- ☐ Memory problems
- ☐ Loss of time
- ☐ Racing heart
- ☐ Nervous or tense
- ☐ Relationship problems
- ☐ Feeling panic or fear
- ☐ Feeling anxious
- ☐ Feeling hopeless
- ☐ Disturbing thoughts
- ☐ Mood Swings
- ☐ Feelings of wanting to die
- ☐ Sadness or depression
- ☐ Confused thinking
- ☐ Concerns about family members
- ☐ Illegal behavior
- ☐ See or hear things others don't
- ☐ Feeling helpless
- ☐ Restlessness
- ☐ Nightmares
- ☐ Worrying
- ☐ Grief or loss
- ☐ Drug or alcohol overuse
- ☐ Concerns about sexual feelings
- ☐ Stomach pain or digestive issues
- ☐ Problems concentrating
- ☐ Feeling worthless
- ☐ Not getting along with others
- ☐ Shaking or trembling
- ☐ Chronic pain
- ☐ Childhood issues
- ☐ Problems with sexual thoughts or behavior
- ☐ Irritable
- ☐ Withdrawn
- ☐ Self-harm behavior
- ☐ Other additive behavior
- ☐ Suicidal thoughts
- ☐ Suicidal plans

Substance Use History:

Alcohol Use: (check all that apply)

1. Frequency of Use: ___None ___Occasionally ___Weekly ___Daily
2. How much? ___None ___1-2 drinks ___3-5 drinks ___More than 5 drinks
3. Drink of choice: ___Beer ___Wine ___Liquor
4. Do you think it's a problem? ___No ___Yes ___Unsure

Drug Use: (circle all that apply)

1. Marijuana: ___None ___Occasionally ___Weekly ___Daily
2. Other: ______________________ ___Occasionally ___Weekly ___Daily
3. Other: ______________________ ___Occasionally ___Weekly ___Daily
4. Any prescription drugs used *not* as prescribed: ________________________________

Trauma History:

List significant life trauma(s) or losses:

Trauma or Loss	Age?

Have you ever attempted suicide? ___ Yes or ___ No If yes, when and how?

____

Childhood and Family History:

1. Growing up, were your parents together? ___ Yes or ___ No.
2. If separated or divorced, at what age were you when that happened? ____
3. If either was deceased, at what age were you when they died? ____. Which parent: ______
4. Did you experience any of the following as a child, adolescent, or young adult?

   ___ School Problems ___ Depression ___ Substance Abuse
   ___ Legal Problems ___ Physical Abuse ___ Sexual Abuse
   ___ Domestic Violence ___ Health Problems

5. Other major childhood issues? ____
6. Is there a history of any of the following issues in your current family or in your family of origin? (check all that apply) ___Substance Abuse ___ Mental Illness ___ Suicide

   If you checked any or all of the above, please provide additional information:

Name	Relationship to You	Issue