**PERSONAL INFORMATION**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| First Name: | Middle Initial: | | | Last Name: | | | | Today’s Date: |
| Mailing/Street Address: | | | | City: | | State: | | Zip: |
| Living area: Home Apartment Mobile Home  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ | | Home:  Own Rent | | | Highest grade or degree completed: | | | Are you currently a student?  Yes No |
| Preferred Phone:  Home Cell Work | May I leave a message? (Not confidential) Yes No | | | Email Address: | | | | May I email You? (Not confidential) Yes No |
| Other Phone:  Home Cell Work | May we leave a message?  Yes No | | | Birth Date: Age: | | | | Sex: |
| Marital/Partnership Status:  Single  Married  Cohabitating  Divorced/Separated  Widowed | | | | | | | | |
| Contact in Case of Emergency: Spouse/Partner Parent Friend Relative Neighbor | | | Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Home Cell Work | |
| Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any cultural things you would like to tell me about? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| Any legal issues in the past or currently? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| Do you or partner view Pornography? Yes No Never Have If yes, How often Daily Weekly Monthly Yearly Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, have you tried to quit? Yes No How many times: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |

**SPOUSAL/PARTNER INFORMATION**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Spouse/Partners First Name: | Middle Initial: | Last Name: | | | Marriage  Cohabitating  Date: |
| Mailing/Street Address: | City: | State: | | | Zip: |
| Preferred Phone:  Home Cell Work | May we leave a message? (Not confidential) Yes No | | | Birthdate: | Sex: M F |
| Employer Name: | | | Employers Address: | | |

**CHILDREN’S INFORMATION: List All Children**

|  |  |  |  |
| --- | --- | --- | --- |
| **First & Last Name:** | **Birthdate:** | **Lives with You?** | **Sex:** |
|  |  | Yes No | M F |
|  |  | Yes No | M F |
|  |  | Yes No | M F |
|  |  | Yes No | M F |
|  |  | Yes No | M F |

**EMPLOYMENT INFORMATION:**

|  |  |  |
| --- | --- | --- |
| Company: | Company’s Address: | Company’s Phone: |
| Do you enjoy your work?   Yes  No | Are there any unusual stressors with your current work? Yes No  If Yes, List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Unemployed?   Yes  No | Reason for unemployment: Fired Lost Job Just graduated Injured Other (explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

**INSURANCE INFORMATION:**

|  |  |  |
| --- | --- | --- |
| Insurance Company Name | Insurance Company Address: | Phone: |
| Policyholder: | Policyholders date of birth: | Applicant’s relationship to policy holder:  Self Spouse Child Other: \_\_\_\_\_\_ |
| Policy Number: | Group Number: | Co-Pay Amount: |
| **PAYMENT FOR SERVICE*: All insurance Co-payments are due at the beginning of each therapy session. Payments can be made in the form of Cash, Check, Visa, MasterCard, HSA and Discover.***  ***Thank you.*** | | |

**SPIRITUALITY/ RELIGION:**

|  |  |
| --- | --- |
| Religious Affiliation, if any: Christian Catholic LDS Muslim Hindi Buddhist Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Actively Involved Member?  Yes  No  Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you consider yourself to be religious or spiritual?  Yes No | Spiritual Practices? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**COUNSELING HISTORY:**

|  |
| --- |
| Previous mental health services (psychotherapy, psychiatric services, etc.)? □ Yes □ No  If yes, please list the previous therapist/practitioner:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Have you ever been prescribed psychotropic medication (e.g. for depression, anxiety, etc.?) □Yes □No  If yes, Please list & provide dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Suicidal thoughts**, if so how often? Everyday Weekly Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Thoughts of harming others**, if so how often? Everyday Weekly Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Adult/Child Abuse** -- Mental Physical Sexual Emotional  **Relationship Issues** -- Parenting Marital/Cohabitating Sibling Friends Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**GENERAL HEALTH & MENTAL HEALTH INFORMATION**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Primary Physician: | | Clinic: | | Address: | | | Phone: |
| Date last seen: | Current Diagnosis: | | | | List of medications: | | |
| How would you rate your current physical health? (Please circle)  1 2 3 4 5 6 7 8 9 10  ***Poor Satisfactory Very Good*** | | | | | | Please list any specific health problems you are currently experiencing: | |
| How would you rate your current sleeping habits? (Please circle)  1 2 3 4 5 6 7 8 9 10  ***Poor Satisfactory Very Good*** | | | | | | Please list any specific sleep problems you are currently experiencing: | |
| ­­­­­­­­­­Please list your experience with appetite or eating patterns.  1 2 3 4 5 6 7 8 9 10  ***Picky Eater Routine Eater Binge Eater*** | | | | | | Do you drink alcohol? Yes No Never If yes how often: Daily Weekly  MonthlyOccasionally | |
| What types of exercise to you participate in? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | How many times per week do you exercise? 1-2X 3-4X  5-7X Other \_\_\_\_\_\_\_\_ | |
| Do you engage recreational drug use?  Yes No Never Have | | | If yes, how often: Daily Weekly Monthly Occasionally | | | | |
| Are you currently in a romantic relationship? Yes No  If yes, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_ | | | How would you rate that relationship?  1 2 3 4 5 6 7 8 9 10  ***Poor Satisfactory Very Good*** | | | | |
| Are there any recent significant life changes or stressful events? If so list:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Were there any significant traumatic past or current events in your life?  If so list: \_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |

**FAMILY MENTAL HEALTH HISTORY:** In the section below identify if there is a **Family History** of any of the following. **If yes**, please indicate the family member’s relationship to you.

|  |
| --- |
| ***If Married/Cohabitating***: Please rate the quality of your immediate family relationships:  1 2 3 4 5 6 7 8 9 10  ***Poor Satisfactory Very Good*** |
| Please rate the quality of your family of origin relationships:  1 2 3 4 5 6 7 8 9 10  ***Poor Satisfactory Very Good*** |
| ***Alcohol/Substance Abuse***: Yes No Parent Sibling Grandparent Other relative, Who:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Anxiety:*** Yes No Parent Sibling Grandparent Other relative, Who:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***ADHD (Inattentive/Impulsive:*** Yes No Parent Sibling Grandparent Other relative, Who:\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Depression:*** Yes No Parent Sibling Grandparent Other relative, Who:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Domestic Violence***: Yes No Parent Sibling Grandparent Other relative, Who:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Eating Disorders:*** Yes No Parent Sibling Grandparent Other relative, Who:\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Obesity:***  Yes No Parent Sibling Grandparent Other relative, Who:\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Obsessive Compulsive Behavior:***Yes No Parent Sibling Grandparent Other relative, Who:\_\_\_\_\_\_\_\_\_\_\_ |
| ***Schizophrenia:*** Yes No Parent Sibling Grandparent Other relative, Who:\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Depression & Suicide Attempts:*** Yes No Parents Sibling Grandparent Other relative, Who:\_\_\_\_\_\_\_\_\_\_\_\_ |

**ADDITIONAL INFORMATION:**

*(Please feel free to use the back if needed)*

What do you consider to be some of your strengths? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

What are your main goals for therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Is there anything else you would like me to know? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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