Name: _____ **Preferred Name:** _____
Last First MI

Address: _____

Best phone number: _____ **Email:** _____

Primary Care Physician: _____**Telephone:** _____

Date of Birth: _____/_____/_____ **Age:** _____

How do you describe your race/ethnicity? _____ **Gender** _____

How do you describe your sexual orientation? _____

How do you describe your religious or spiritual beliefs? _____

Current marital status (Check one):

☐ Single, never married ☐ Married, living together ☐ Separated ☐ Widowed
☐ Cohabiting with partner ☐ Divorced ☐ Married, not living together

On a scale from 1(*not well at all*) to 10(*very good*) how would you rate your current relationship? _____

Highest degree obtained: (Check only one)

☐ High school graduate ☐ G.E.D. ☐ 4-year college degree ☐ Masters. ☐ M.D.
☐ Junior college degree or technical school diploma ☐ Ph.D ☐ Other_____

What best describes your current employment status?

☐ Unemployed, not looking for employment ☐ Unemployed, looking for employment ☐ Full-time employed
☐ Part-time employed ☐ Retired ☐ Self-employed

What is your occupation? _____

Please briefly state the primary reason for your visit today:

Are you <u>currently</u> receiving mental health care? ☐ YES ☐ NO

(*if yes*) Name: _____ Contact Number: _____

Have you <u>ever</u> seen a counselor/psychiatrist/psychotherapist before? ☐ YES ☐ NO

(*if yes*) Name: _____ Contact Number: _____

Was it helpful? _____

Previous mental history: Have you ever been treated for any of the following (check all that apply):

_____ Depression
_____ Anxiety
_____ Panic Attacks
_____ Anorexia/ Bulimia
_____ ADHD
_____ OCD
_____ PTSD
_____ Binge-eating
_____ Bipolar (Manic / Depressive) Disorder
_____ Schizophrenia
_____ Personality Disorders
_____ Alcohol Problems (including AA)
_____ Substance Use
_____ Suicidal or self-injurious behavior
_____ Relationship difficulties
_____ Problems coping with stress
_____ Phobias
_____ Other _____

On a scale of 1-10, how would you rate your current sleep habits? _____
(1 not well at all – 10 very good)

On a scale of 1-10, how would you rate your current eating habits? _____
(1 not well at all – 10 very good)

Have you ever been hospitalized for psychiatric reasons? ☐ YES ☐ NO
If yes, please provide details below:

Have you ever attempted to kill or harm yourself? ☐ YES ☐ NO ☐ More than 3 times

Please list all <u>CURRENT MEDICATIONS</u> below:

<u>Name of Medication</u> **<u>Dosage</u>**

Have you been prescribed psychiatric medication in the past? ☐ YES ☐ NO
If yes, please provide details below:

Family History: Has anyone in your family ever been treated for any of the following? If yes, please indicate on the line provided which family member and, if applicable, whether on mother's side or father's side.

____ Depression _____

____ Anxiety _____

____ Panic Attack _____

____ Post-traumatic Stress _____

____ Bipolar/Manic Depression _____

____ Schizophrenia _____

____ Personality Disorders _____

____ Alcohol Problems _____

____ Substance Use _____

____ ADHD _____

____ Suicide Attempts _____

____ Psychiatric Hospital Stay _____

Medical History: Do you have, or have you ever had any of the following? Please check all that apply.

____ High Blood Pressure
____ Lung Disease
____ Diabetes
____ Heart Disease
____ Thyroid Disease
____ Anemia
____ Asthma
____ Skin Disease
____ Seizures
____ Gastrointestinal Problems (ulcers, pancreatitis, irritable bowel, colitis)
____ Arthritis or Rheumatoid Problems
____ Liver Damage or Hepatitis
____ Other Endocrine/Hormone Problems
____ Neurological Problems (stroke, brain tumor, nerve damage)
____ Gynecological / hysterectomy
____ Urinary Tract or Kidney Problems
____ Migraine or Cluster Headaches
____ Ear/Nose/Throat Problems
____ Viral Illness (herpes, chronic hepatitis)
____ Cancer
____ Genital Problems
____ Eating Disorder
____ Eye Problems
____ Chronic pain
____ Fibromyalgia
____ HIV Positive or AIDS
____ Head Injury
____ High Cholesterol
____ Sleep apnea

Allergies: _____

Do you drink alcohol? ☐ YES ☐ NO

When was your last alcoholic drink? _____

How many drinks do you have on average each week? _____

Do you use tobacco? ☐ YES ☐ NO

Do you have any concerns for substance use or abuse currently? ☐ YES ☐ NO

Please Explain

Do any of the following apply to you?

____ Problems with family or friends *Specify*: _____

____ Emotional problems *Specify*: _____

____ Occupational problems *Specify*: _____

____ Housing problems *Specify*: _____

____ Economic problems *Specify*: _____

____ Problems with access to health care services *Specify*: _____

____ Problems related to interaction with the legal system/crime *Specify*: _____

____ Other psychosocial and environment problems *Specify*: _____

____ Past Trauma *Specify*: _____

____ Legal Issues *Specify*: _____

What outcome are you seeking by attending therapy at this time?

Is there anything else you would like your counselor to know about you or your reason for seeking professional counseling today?