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 ever 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 CURRENT MEDICATIONS below:

Name of Medication	**Dosage**

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?