

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 currently 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):

- | | |
|--|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Personality Disorders |
| <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Alcohol Problems (including AA) |
| <input type="checkbox"/> Anorexia/ Bulimia | <input type="checkbox"/> Substance Use |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Suicidal or self-injurious behavior |
| <input type="checkbox"/> OCD | <input type="checkbox"/> Relationship difficulties |
| <input type="checkbox"/> PTSD | <input type="checkbox"/> Problems coping with stress |
| <input type="checkbox"/> Binge-eating | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Bipolar (Manic / Depressive) Disorder | <input type="checkbox"/> 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 | ___ Gynecological / hysterectomy |
| ___ Lung Disease | ___ Urinary Tract or Kidney Problems |
| ___ Diabetes | ___ Migraine or Cluster Headaches |
| ___ Heart Disease | ___ Ear/Nose/Throat Problems |
| ___ Thyroid Disease | ___ Viral Illness (herpes, chronic hepatitis) |
| ___ Anemia | ___ Cancer |
| ___ Asthma | ___ Genital Problems |
| ___ Skin Disease | ___ Eating Disorder |
| ___ Seizures | ___ Eye Problems |
| ___ Gastrointestinal Problems (ulcers, pancreatitis, irritable bowel, colitis) | ___ Chronic pain |
| ___ Arthritis or Rheumatoid Problems | ___ Fibromyalgia |
| ___ Liver Damage or Hepatitis | ___ HIV Positive or AIDS |
| ___ Other Endocrine/Hormone Problems | ___ Head Injury |
| ___ Neurological Problems (stroke, brain tumor, nerve damage) | ___ 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?