|  |  |  |
| --- | --- | --- |
| Today’s Date: |  |  |
| Name: |  | Age: |  | DOB: |  |
| Address: |  | City & Zip Code: |  |  |
| Primary Phone #: |  | Home/Cell/Work – May I leave Message?  | [ ]  Yes [ ]  No |  |
| Alternate Phone #: |  | Home/Cell/Work – May I leave Message?  | [ ]  Yes [ ]  No |  |
| Email: |  |  | Business #: |  |  |
| Occupation: |  |  |
| Emergency Contact: |  | Relationship to Client:  |  |  |
| Emergency Contact #: |  |  |  |  |
| Currently enrolled/attending school?: | [ ]  Yes [ ]  No |  |
| Are you currently serving/have a history of serving in the military? | [ ]  Yes [ ]  No |  |
|  |  |  |
| How were you referred? |  |  |
|  |
| **\*\*\*Email & Text Message correspondence are not considered a confidential medium of communication\*\*\*** |
| Primary Language: |  | Secondary Language: |  |  |
| Ethnicity: |  | Religious/Spiritual Affiliation: |  |  |
| Marital Status: | [ ]  Married[ ]  Separated | [ ]  Cohabitating[ ]  Divorced | [ ]  Domestic Partnership[ ]  Widowed | [ ]  Never Married |  |
| Current Living Situation: |  |  |
|  |
| Children: | [ ]  Yes [ ]  No | If yes, children’s ages: |  |  |
|  |
| **Complete if client is under the age of 18** |
| Parent/Legal Guardian #1 Name: |  | Age: |  | DOB: |  |  |
| Primary Phone Number: |  | [ ]  Home [ ]  Work [ ]  Cell |  |
| Address: |  | City & Zip Code: |  |  |
|  |
| Parent/Legal Guardian #1 Name: |   | Age: |  | DOB: |  |  |
| Primary Phone Number: |  | [ ]  Home [ ]  Work [ ]  Cell |  |
| Address: |  | City & Zip Code:  |  |  |
|  |  |  |
| Legal Custody of Minor Held by: |   |  |
| Physical Custody of Minor Held by: |  |  |
|  |  |  |
| **Medical Information** |
| Have you had a physical with a physician in the last year? Yes [ ]  No [ ]  |
| Do you exercise? Yes [ ]  No [ ]  |
| If yes, please describe your exercise routine/activities: |  |  |
| Do you have a history of or currently experience any medical/health issues? | Yes [ ]  No [ ]  |  |
| If yes, please describe: |  |  |
|  |
| Current medications/vitamins/herbal supplements: |  |  |
| Are you experiencing any of the below symptoms: |  |
| [ ]  Sleep Disturbances [ ]  Loss/increase in appetite [ ]  Sudden loss/increase in energy[ ]  Headaches [ ]  Vision Problems [ ]  Dizziness/Fainting [ ]  Hearing Problems |  |
| How often do you consume alcoholic beverages? |  |
| [ ]  Infrequently [ ]  Monthly [ ]  Weekly [ ]  Daily [ ]  Never |  |
|  |  |
| How often do you engage in recreational drug use? |  |
| [ ]  Infrequently [ ]  Monthly [ ]  Weekly [ ]  Daily [ ]  Never |  |
|  |  |
| **Mental Health Information** |  |
| Have you ever received/currently receiving any type of mental health services? Yes [ ]  No [ ]   |  |
| If “yes”, name of therapist, approximate dates and focus of treatment: |  |
|  |
|  |  |
| Have you ever received psychiatric services? Yes [ ]  No [ ]   |  |
| If “yes”, name of psychiatrist approximate dates and focus of treatment: |  |
|  |
|  |  |
| Are you currently taking psychotropic medications? Yes [ ]  No [ ]   |  |
| If yes, please list medications: |  |
|  |
| Do you have a history of taking prescribed psychotropic medications? Yes [ ]  No [ ]  |
| If yes, please list medications: |  |
|  |  |
| Have you ever experienced the following symptoms? |
| [ ]  Anxiety | [ ]  Depression | [ ]  Phobias | [ ]  Panic Attacks | [ ]  Flashbacks | [ ]  Chronic Pain |
| [ ]  Grief | [ ]  Suicidal thoughts/feelings | [ ]  Thoughts/feelings of wanting to harm self |
|  |  |  |
| Have you ever experienced or encountered any of the following? |
| [ ]  Emotional Abuse | [ ]  Physical Abuse | [ ]  Sexual Abuse |
| [ ]  Neglect | [ ]  Living in Foster Care | [ ]  Violence in the home |
| [ ]  Multiple homes/living situations | [ ]  Victim of Crime | [ ]  Homelessness |
| [ ]  Substance use by parent | [ ]  Substance use by partner | [ ]  Loss of loved one |
| [ ]  Financial hardship | [ ]  Major Surgery/Medical Procedure | [ ]  Major accident/serious illness |
|  |  |  |
| Do you have a family history of the following (if yes, indicate the family member’s relationship to you in the space provided to the right)? |
| Alcohol/Substance Use |  | Y [ ]  N [ ]  |  |
| Anxiety |  | Y [ ]  N [ ]  |  |
| Bi-Polar Disorder | Y [ ]  N [ ]  |  |
| Depression | Y [ ]  N [ ]  |  |
| Domestic Violence | Y [ ]  N [ ]  |  |
| Eating Disorders | Y [ ]  N [ ]  |  |
| Obesity | Y [ ]  N [ ]  |  |
| Obsessive Compulsive Behaviors | Y [ ]  N [ ]  |  |
| Post-Traumatic Stress Disorder | Y [ ]  N [ ]  |  |
| Schizophrenia | Y [ ]  N [ ]  |  |
| Suicidal Ideation/Behaviors  | Y [ ]  N [ ]  |  |
|  |

**Therapeutic Focus**

Please identify any of the below concerns that you would like to work on and/or areas you would like to receive support with during therapy:

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  Accident or injury | [ ]  Addiction | [ ]  Alcohol or Drugs | [ ]  Anger |
| [ ]  Bereavement | [ ]  Career Goals | [ ]  Child/Parenting | [ ]  Communication |
| [ ]  Conflict Resolution | [ ]  Depression | [ ]  Disturbing/troubling thoughts |
| [ ]  Divorce/Separation | [ ]  Familial Conflict | [ ]  Gender identity | [ ]  Grief |
| [ ]  Hopelessness | [ ]  Infertility | [ ]  In-laws | [ ]  Intimacy Barriers |
| [ ]  Job related issues | [ ]  Loss | [ ]  Marriage | [ ]  Motivation |
| [ ]  Pregnancy | [ ]  Relationship | [ ]  School | [ ]  Self-Esteem |
| [ ]  Sexuality | [ ]  Spirituality | [ ]  Stress | [ ]  Suicidal Thoughts |
| [ ]  Trauma | [ ]  Anxiety | [ ]  Postpartum related issues |

Any additional information related to why you are seeking therapy at this time or what may be helpful for your therapist to know:

|  |
| --- |
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|  |