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| 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 | | | | | | | | | | | | | | | | | | | |  | | |
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| How were you referred? | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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| **\*\*\*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: | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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| Children: | | | | | | | | | Yes  No | | | | | | | | | | | If yes, children’s ages: | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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| **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: | | | | | | | | | | | | | |  | | | | | | | | | |  | |
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| Parent/Legal Guardian #1 Name: | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Age: | | | |  | | | | | | DOB: | | | |  | |  | | |
| Primary Phone Number: | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Home  Work  Cell | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| Address: | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | City & Zip Code: | | | | | | | | | | | | | |  | | | | | | | | | |  | | |
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| Legal Custody of Minor Held by: | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| Physical Custody of Minor Held by: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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| **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: | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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| 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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| How often do you engage in recreational drug use? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| Infrequently  Monthly  Weekly  Daily  Never | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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| **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: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
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| Have you ever received psychiatric services? Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| If “yes”, name of psychiatrist approximate dates and focus of treatment: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
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| Are you currently taking psychotropic medications? Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| If yes, please list medications: | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Do you have a history of taking prescribed psychotropic medications? Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If yes, please list medications: | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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 | | | | | | | | | | | | | | | | | |
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| 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 | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
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**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:

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| 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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