The following necessary information will help make your first session most productive. Please **PRINT** and fill out this form **COMPLETELY**.

DEMOGRAPHICS **Date:** _____

Last Name First Middle Date of Birth Age

_____

Preferred Name to be called

_____

Residence Address City State Zip Code

Telephone (cell) (Home) EMAIL

Gender ☐ Male ☐ Female ☐ Other _____

Marital Status

☐ Single ☐ Married ☐ Separated ☐ Divorced
☐ Remarried ☐ Partnered ☐ Widowed

Personal History

Why are you seeking treatment at this time?

_____
_____
_____
_____

Are there any situational stressors or triggers that make the issue more intense?

_____
_____

What do you need help with? (Check all that apply)

☐ Anxiety ☐ ADHD ☐ Employment/school
☐ Depression ☐ Mood Swings ☐ Physical/Medical
☐ Relationship problems ☐ Grief/Death ☐ Psychosis
☐ Extramarital Affair ☐ Abuse _____
☐ Children/Parenting ☐ Addiction _____
☐ PTSD/Trauma ☐ Other _____

Have there been any significant life events the therapist should know about?

_____
_____
_____
_____

Mental Health

Have you had any of the following within the past 90 days? (Check all that apply)

☐ Suicidal thoughts	☐ Suicidal attempts	☐ Suicidal plans
☐ Self Injury	☐ Depression	☐ Impulsive
☐ Anxiety	☐ Hospitalization	☐ Panic/Phobia
☐ Mood Swings	☐ Sleep issues	☐ Death
☐ Appetite change	☐ Violence	☐ Anger issues
☐ Weight gain/loss	☐ Racing thoughts	☐ Obsessive/intrusive thoughts
☐Thoughts of harming other	☐ Hallucinations/Delusions	☐ Change in energy levels
☐ Death of someone close	☐ Paranoia	

Have you ever been in Counseling before? ☐ Yes ☐ No

Dates	Counselor Name	Reason for Discontinuing/discharge	Diagnosis given

Starting with most current, please list current and past mental/behavioral health medications:

Medication	Dose	Reason	Doctor	Still taking?

Have you ever taken mental/behavioral health medications in the past? ☐ Yes ☐ No
If yes, please list: _____

Have you ever been admitted into a hospital for mental/behavioral health? ☐ Yes ☐ No
If yes, please list: _____
Dates Location Reason

Have you ever tried to commit suicide? ☐ Yes ☐ No
Have you ever had thoughts or plans of hurting yourself? ☐ Yes ☐ No
Have you or ever had self-harming behaviors? ☐ Yes ☐ No
Have you or are you having any eating issues? ☐ Yes ☐ No
*If yes, how long ago: _____
Is there any family history of mental health problems or suicide (attempts)? ☐ Yes ☐ No
If yes, please explain: _____
_____

Has there been any history of abuse? ☐ Yes ☐ No
Type of abuse:
☐ Physical
☐ Emotional
☐ Sexual

Medical

Who is your primary care physician? (Name and address) _____
_____

Do you currently have any medical problems? ☐ Yes ☐ No
Please list all symptoms:
_____
_____
_____

Medications taking right now:

Medication	Dosage	Reason	Doctor

Employment/Education

Are you currently employed? ☐ Yes ☐ No

Company Name Length employed Feelings about job

Highest level of education did you complete: _____

Are you currently a student? ☐ Yes ☐ No

_____

Last School attended Grade level GPA

Legal Issues:

Do you have any past/current legal/court cases? ☐ Yes ☐ No

IF yes: ☐ Civil ☐ Criminal

Please describe:

_____

_____

_____

Will you require reports for court purposes? ☐ Yes ☐ No

Substance Use:

Have you ever used or are you currently using any substances? ☐ Yes ☐ No
Have you ever felt guilt or remorse about your substance use? ☐ Yes ☐ No
Have you ever tried to stop and have been unsuccessful? ☐ Yes ☐ No
Is there any family history of substance abuse? ☐ Yes ☐ No

Substance Type	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in the last 48 hours		Used in the last 30 days	
					Yes	No	Yes	No
Alcohol								
Barbiturates								
Cocaine/Crack								
Hallucinogens								
Heroin								
Opiates								
Inhalants								
Marijuana								
Methadone								
Methamphetamines								
Prescription Pills [1]								
Steroids								
Other _____								

[1] Circle all that apply: Lortab, OxyContin , Darvocet , Percocet , Xanax , Soma , Valium
IF the prescription drug is not here please discuss in your session.

Family History

Who were you raised by? _____

Describe your relationship with your parents/caregivers:

_____
_____
_____

How many siblings do you have? _____
Describe names, ages, and respective relationship with your siblings:

_____
_____
_____
_____

Do you have any children? ☐ Yes ☐ No
How many pregnancy? _____ How many live births? _____ How many non-live births? _____

Describe names, ages, and respective relationships with your children:

_____
_____
_____
_____
_____

What type of discipline is used in your home?

_____
_____
_____
_____

Social/ Support System:

Describe the relationship with your spouse or partner:

_____
_____
_____
_____
_____

Describe your current living situation? Ie. Who lives with you? What is the environment around the home? Is the living situation safe?

_____
_____
_____
_____
_____
_____

Who is your support system?

_____
_____
_____

Please list all family members and ages that will be involved in treatment?

_____
_____
_____

What do you hope to gain out of treatment?

_____
_____
_____
_____
_____

Spiritual/Religious beliefs?

_____
_____

Patient Name Patient Signature Date