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Your Information

Please fill out and bring to first session with you

Name _____ Date_____

Gender Identity/Sexual Orientation_____

Date of birth _____ Age_____

Home Address_____

City/State _____ Zip_____

Email_____

Primary Phone (home/cell/work)_____
Check if o.k. to leave message_____
Alternate Phone (home/cell/work)_____ \
Check if o.k. to leave message_____

Relationship status: single_____separated_____married_____

divorced_____ (#of times_____) committed relationship_____ widowed_____

How long with current partner?_____Living together?_____How long?_____

Children (names and ages)_____

Who lives in your household?_____

Name Relationship Phone

Emergency Contact(s) _____

_____

Education_____

Occupation_____ Employer_____

How many hours do you work a week?_____

Ethnic/Cultural Background (optional)_____

Spiritual Practice/Religious Affiliation (optional)_____

How did you find me? _____

Family History

In a few words, describe what your relationship has been like with your

Mother:_____

_____

_____

Father: _____

_____

_____

Brothers and sisters (include names and ages): _____

_____

_____

_____

_____

_____

Other significant family members: _____

_____

_____

Before you were 18, did you experience any of the following?:

____ Raised by someone other than parent (who? _____)

____ Parents divorced (your age ____)

____ Lived with step-parent or other siblings

____ Adopted (at what age? ____)

____ Other_____

Have you experienced the death of someone close to you? (yes/no)

Please give the name and relationship of the person(s), cause of death, and when they died (or your age at the time):_____

_____

_____

_____

Did either of your parents abuse alcohol or other drugs? _____

_____

_____

Were the adults in your household abusive or disrespectful to each other? _____

_____

_____

Were you verbally, emotionally, sexually, physically abused or neglected? _____

_____

_____

_____

Do any of your current or extended family members have a history of mental illness (depression, anxiety, attention deficit disorder, addictions, etc.)? _____

_____

_____

_____

Has anyone close to you committed suicide or attempted to commit suicide? _____

_____

_____

_____

Is there anything that troubles you about your childhood (family, school social, etc.)? _____

_____

_____

Health

Current physical health concerns (including chronic conditions): _____

_____

_____

_____

Do you follow a specific diet? _____ Why?_____

Current prescribed medications you are taking and condition addressed: _____

_____

_____

_____

Previous medical hospitalizations, serious illnesses or injuries, seizures, or head injuries:_____

_____

_____

_____

_____

Describe your exercise habits:_____

_____

_____

Previous counseling experiences (include approximate dates, length of time, and reasons):_____

_____

_____

_____

Was it helpful?_____

Do you have any previous mental health diagnoses? _____

_____

_____

Have you ever been hospitalized for mental illness? _____

_____

Have you ever attempted suicide or had serious thoughts of suicide? If yes, when and why? ____

_____

_____

_____

How often do you use alcohol or other drugs?

daily ____ 1-2 times/week ____ 2-5 times/week ____

1-2 times/month____ less than once/month____

Type of alcohol or drugs consumed and amount: _____

_____

_____

_____

Has your alcohol or drug use caused problems in your life? (please explain): _____

_____

_____

_____

Describe your media consumptions habits (TV, movies, Internet, news, Facebook, etc…)_____

_____

_____

_____

Have you struggled with any other behaviors that felt compulsive or difficult to control such as overeating, an eating disorder, pornography use, gambling, spending money, internet use/gaming, excessive sexual activity, etc.? Please describe briefly and indicate whether it is past or present._____

_____

_____

_____

_____

Is there anything in your sexual history that disturbs you? _____

_____

_____

Self Care

What are the major stresses in your life? _____

_____

_____

What do you do to relax or relieve stress? _____

Do you have coping skills that you use? _____

Who can you turn to for emotional support? _____

How much do you typically sleep? Do you have any sleep problems? _____

Therapy Goals

What brings you to therapy at this time? (Please describe the issues and concerns for which you are seeking counseling.) _____

How do you hope your life will be different after counseling? _____