



Name: _____

Date of Birth: _____ / _____ / _____

Address: _____

Phone number: _____ - _____ - _____

Email address: _____

What brought you to therapy today?

Have you ever been to therapy before? If so, what was your experience like?

Physical Information:

Please list any chronic medical conditions:

Please list all medication prescribed by a doctor along with the doctor's name and specialty.

Please list any over the counter medication and/or vitamins and supplements that you take.

Please describe your sleep patterns. How long do you typically sleep? Do you wake during the night? Do you have trouble falling asleep? Is your sleep disturbed by other people? Are you diagnosed with a sleep disorder?

Please describe your food patterns. Do you eat at home or out of the house? Where do you eat at work? How many meals a day do you have? Do you wish there was anything different about your food intake? Do you have a philosophy when it comes to food?

Do you have any concerns when it comes to your physical health?

Do you have an OB/GYN? If so, please list the name of the person.

Do you have a psychiatrist? If so, please list the name of the person.

Is there a chronic condition that runs in your family?

Mental Health

Do you currently have a mental health diagnosis by a professional?

Have you had a mental health diagnosis by a professional in the past?

Do you believe that you have a mental health diagnosis? If so, what do you believe it is?

Have you ever been inpatient in a hospital for mental health? If so, when was that?

Have you ever been in residential treatment for mental health?

Is there a family member that has a mental health diagnosis?

Have you ever been verbally, physically, or sexually abused as a child (under 18)?

Have you ever been verbally, physically or sexually abused as an adult?

Have you or anyone in your immediate family attempted suicide or homicide?

Have you ever had any thoughts about killing yourself?

Do you currently have a plan to kill yourself?

Have you ever wished you were dead?

Do you have nightmares or flashbacks? If so, how often?

In the last month, have you been continuously irritable or have outbursts of anger?

Have you had trouble focusing or concentrating recently?

Have you ever had a panic attack that may or may not have included difficulty breathing, sweating, chest pain, nausea, or dizziness? If so, are you afraid it will happen again?

Do you find social situations hard?

In the last two weeks, have you been able to enjoy the things that you have always enjoyed?

In the last month, did you feel sad most of the time?

Are you bothered by recurrent thoughts, impulses, or images that were unwanted or distressing?

Did someone close to you die recently?

Support System

Do you believe that you have a good support system of trusted people?

Do you believe your family is supportive of you and your feelings?

Would you like to increase your support system?

Growing up, did your family have a good support system?

Home

In what type of dwelling do you reside? Who lives with you? Do you have any pets?

Where did you live as a child and adolescent?

Substance Use

Please describe your alcohol consumption. How much do you drink when you drink? How many times a week do you drink? Do you drink more than you would like to drink? Is there a drink you prefer more than others? Was there a time in your life when you drank more than you do now? How old were you when you started to drink?

Please describe any illegal drug use. How often during the week do you use drugs? What drugs do you use? Do you use drugs more than you would like to? Was there a time in your life when you used more drugs than you do now? How old were you when you started using drugs?

Have you ever been to a rehabilitation center for drugs or alcohol? If so, how many times?

Please describe your caffeine intake. On a typical day, how much do you consume? Do you have any physical symptoms if you refrain from caffeine? What times of day do you consume caffeine?

Behavioral Patterns

Do you eat more than you want to? Is your food intake mostly normal except at certain times when you eat more than you want? Have you ever made yourself throw up after you ate too much? Do you use laxatives to keep your weight in a normal range? When you eat do you experience guilt or shame? Have you lost or gained weight recently? Have you ever been treated for an eating disorder?

Do you use relationships to feel better? Do you ever find yourself engaging sexually with others without really wanting to? Do you consistently choose sexual partners that do not respect you?

How often during the day do you check social media? How much time do you spend playing video games?

Has gambling ever been a problem for you? Does anyone in your family think that gambling is a problem?

Spirituality/Religion

Please describe your spirituality or religion as you define it? Is it an important part of your life? Was there a time when it was more or less important than it is now?

Employment

Have you had a consistent pattern of employment since the end of school?

Where are you working now? Please very briefly describe your job.

Does your work environment cause you stress?

Would you like to switch jobs or careers? Would you like anything about work to change?

School

Are you currently in school? When was the last time you attended school?

Would you like to go to school?

If you attended college, which college/colleges did you attend? What was your major?

Military

Have you ever been in the military? If so, what branch? How long?

Did you see combat?

Did you believe the military impacted your life or your family's life in a negative way?

Legal

In the last six months did you need to hire an attorney?

Have you ever been convicted on an alcohol or drug related offense including a DUI?

Have you ever been incarcerated?