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Please fill out form as completely as possible, it will assist in our work together.

Date: _____

Name: _____

Address: _____

Phone numbers: Cell/Home: _____ Work: _____

Email: _____

Date of Birth: _____ **Gender**: _____

Emergency Contact name: _____

Phone Number: _____

Referred by: _____

Single/Married/In committed relationship (CIRCLE ONE)

People in your household; name, age, relationship to you:

_____

_____

Occupation: _____

Presenting Problem (When did it start, how does it impact your life)?

_____

_____

_____

_____

How severe does this problem feel?

Mild___ Moderate____ Severe ___Acute____

What are you looking for in counseling at this time?

_____

_____

_____

Describe any history of suicide attempts

_____

Have you been in counseling before? When, for what purpose, with whom, and was it helpful?

_____

_____

_____

When was your last medical checkup? What are your health challenges?

_____

_____

Please list all medications you are currently taking? Who is the physician overseeing this part of your healthcare?

_____

_____

_____

Let me know about the following in your daily life:

Exercise_____

Diet_____

Caffeine_____

Nicotine_____

Alcohol/other substances _____

How important are the following to you?

Relaxation _____

_____

Religion/Spirituality _____

_____

Activities you enjoy _____

_____

Tell me something important to you about each of the following areas:

Your Childhood _____

_____

Academic/Employment History _____

_____

Relationship History _____

_____

Medical History _____

_____

Significant life losses _____

_____

Anything else you'd like to share _____

_____

_____

_____