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Please answer the questions below as completely as possible, leaving the shaded areas blank.

1. Personal Information

Name _____ Date _____
Age _____ DOB _____ Gender ☐M ☐F ☐M-F ☐F-M ☐Other _____
Address _____ Home phone _____
_____ Cell phone _____
Email address _____ Race/Ethnicity _____
Primary Language _____
How did you hear about my psychotherapy practice? _____

Emergency Contact

1. _____ Phone: _____ Relation: _____

Medical & Psychiatric Care

Do you have a primary medical provider? ☐Yes ☐No
If yes, who? _____ Phone number: _____
Do you have a psychiatrist? ☐Yes ☐No
If yes, who? _____ Phone number: _____

2. Presenting Concerns: *Please provide a brief description of what brings you in for therapy.*

1. _____
2. _____
3. _____
4. _____

How, if at all, do the above issues affect the following areas of your life:
Work and/or school: _____
_____
Relationships: _____
_____
Daily responsibilities (e.g., bills, chores): _____
_____
Other: _____

For Office Use Only (Onset, FID, difficulty, impairment, previous level of fx., past attempts to resolve)

_____

_____

_____

_____

3. Goals for Psychotherapy: *Briefly describe goals you have for your psychotherapy.*

1. _____
2. _____
3. _____
4. _____

4. Safety Issues

Are you seriously thinking about harming/killing yourself? ☐Yes ☐No

If yes, how often do you think about this? ☐Hourly ☐Daily ☐Couple time/wk. ☐ Couple times/mo.

How would you do it? _____

Have you decided when you will do it? ☐Yes ☐No If yes, when? _____

Are you seriously thinking about harming/killing someone else? ☐Yes ☐No

If yes, who? _____

How often do you think about this? ☐Hourly ☐Daily ☐Couple time/wk. ☐ Couple times/mo.

How would you do it? _____

Have you decided when you will do it? ☐Yes ☐No If yes, when? _____

Are you concerned about child abuse you have knowledge of? ☐Yes ☐No

Are you concerned about elder abuse you have knowledge of? ☐Yes ☐No

Is violence a concern in your current relationships? ☐Yes ☐No ☐I don't know

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_____

5. General Information: *Mark all that apply to you.*

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Plural/Poly/Open Relationship ☐ Other

☐ I live alone	☐ My housing is stable	☐ I rent
☐ I live with roommates	☐ My housing is unstable	☐ I own my home
☐ I live with family	☐ I am homeless	

6. Family & Psychosocial History

Family of Origin

Were you adopted? ☐Yes ☐No

Did your parents divorce? ☐Yes ☐No If yes, when? _____

Mother: ☐ Alive ☐ Deceased Relationship quality (in 2-3 words) _____

Father: ☐ Alive ☐ Deceased Relationship quality (in 2-3 words) _____

Do you have any siblings? ☐Yes ☐No If yes, how many? _____

Please describe any family history of mental health diagnoses: _____

_____

Adult Family

Current relationship status *(mark all that apply)*

☐Single ☐Dating ☐Committed relationship ☐Open relationship ☐ Polyamorous

☐Married ☐Widowed ☐Divorced ☐Other: _____

Gender of partner: ☐M ☐F ☐M-F ☐F-M ☐Other: _____

Do you have children? ☐Yes ☐No If yes, what are their ages? _____

Have you experienced any losses in your adult family (e.g., partner, child)? _____

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_____

7. Social History

Who are your primary sources of social support (e.g., friends, family, spiritual community)? _____

_____

_____

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_____

_____

8. Educational/Occupational History

Educational History

How did you perform academically in grammar school? ☐Did well ☐Did fair ☐Did poorly

How did you perform academically in high school? ☐Did well ☐Did fair ☐Did poorly

What is your highest level of education? _____

Occupational History

Which describes your work history? ☐Off & on employment ☐Steady employment ☐ Not working

What type of work, if any, have you done most recently? _____

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_____

9. Current Medications: *Please list all medications and supplements, what they are used for, and how you take them.*

Medication/Supplement Name	Dosage/Route	Frequency	What Does It Treat?

10. Medical Conditions, History, & Lifestyle

Medical Conditions

_____

_____

_____

_____

Physical Pain: ☐Yes ☐No

If yes, where?

_____

_____

Please rate: ____ / 10

Allergies: Please list med allergies.

_____

_____

_____

_____

Lifestyle

How is your appetite? ☐Good ☐Fair ☐Poor

How many **meals**/day? _____

How many servings of **caffeine**/day? _____

How many times do you **exercise**/week? _____

How many hours of **sleep**/night? _____

Do you smoke tobacco? ☐Yes ☐No If yes, how many cigarettes per day? _____

What do you do for **enjoyment**? _____

How do you **relax**? _____

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_____

_____

11. Mental Health History

Mental Health History

Have you ever received a mental health diagnosis? ☐Yes ☐No ☐I don't know

If yes, which? _____

When (mo./yr.) & by whom? _____

Have you been in therapy before? ☐Yes ☐No

If yes, when (mo./yr.)? _____

Therapist(s) name(s): _____ _____

_____ _____

Previous psychiatric medications? ☐Yes ☐No If yes, which? _____

Have you ever attempted to kill yourself in the past? ☐Yes ☐No If yes, when? _____

Have you ever been psychiatrically hospitalized? ☐Yes ☐No If yes, when? _____

Where? _____

Do you have a history of violence? ☐Yes ☐No If yes, when? _____

Have you ever had a whiplash? ☐Yes ☐No If yes, when? _____

Have you ever had a head injury? ☐Yes ☐No If yes, when? _____

12. History of Adverse Events/Trauma

Childhood

Please briefly describe any significant, traumatic, or difficult experiences from **childhood** (e.g. losses, abuse, bullying).

_____

_____

_____

Adolescence

Please briefly describe any significant, traumatic, or difficult experiences from **adolescence** (e.g. legal involvement).

_____

_____

_____

Adulthood

Please briefly describe any significant, traumatic, or difficult experiences from **adulthood** (e.g., losses, traumas, military).

_____

_____

_____

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_____

13. Alcohol & Drug Use

Current Alcohol Use

Do you drink alcohol? ☐Yes ☐No

What type? ☐Liquor ☐Beer ☐ Wine

How often do you drink? ☐Daily ☐Weekly ☐Monthly ☐Couple times per year

How many servings at a time? ☐1-2 ☐3-5 ☐more than 5

Please describe any concerns you have about your use: _____

Does anyone in your family have a problem with alcohol? _____

Have you ever tried to cut back on your alcohol use? ☐Yes ☐No

Past Alcohol Use/Treatment

Has alcohol been a problem for you in the past? ☐Yes ☐No

Have you ever been in treatment for alcohol use? ☐Yes ☐No

If yes, when? (mo./yr.) _____

Type of treatment? ☐Inpatient ☐Outpatient ☐12-Step ☐Other: _____

Current Drug Use

Do you use drugs? ☐Yes ☐No

If yes, please list all? _____

Which are your drugs of choice? _____

How often do you use? ☐Daily ☐Weekly ☐Monthly ☐Couple times per year

Reason(s) for use: ☐Addicted ☐Build confidence ☐Escape ☐Self-medication ☐Socialization ☐Other _____

Please describe any concerns you have about your use: _____

_____

Does anyone in your family have a problem with drug use? _____

Have you ever tried to cut back on your drug use? ☐Yes ☐No

Past Drug Use/Treatment

Have drugs ever been a problem for you in the past? ☐Yes ☐No

Have you ever been in treatment for your drug use? ☐Yes ☐No

If yes, when? (mo./yr.) _____

Type of treatment? ☐Inpatient ☐Outpatient ☐12-Step ☐Other: _____

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_____

_____

14. Developmental History: *Please describe any delays in your physical/mental/emotional/educational development you experienced while growing up.*

_____

_____

_____

_____

15. Legal History

Have you been divorced? ☐Yes ☐No

Have you ever been arrested? ☐Yes ☐No If yes, when? _____

What for? _____

Have you ever been incarcerated? ☐Yes ☐No If yes, when? _____

What for? _____

16. Personal Strengths: *Check all that apply to you*

☐ Willing to try new things	☐ Proactive	☐ Strong work ethic
☐ Good communication	☐ Good health	☐ Self confidence
☐ Community involvement	☐ Adaptable	☐ Sense of humor
☐ Access to resources	☐ Organized	☐ Learn quickly
☐ Adequate social support	☐ Energetic	☐ Manage daily tasks
☐ Strong coping skills	☐ Sociable	☐ Positive attitude
☐ Manage time wisely	☐ Creative	☐ Work experience
☐ Have long-range goals	☐ Optimistic	☐ Marketable skills
☐ Willing to work hard	☐ Responsible	☐ Enthusiastic

Other strengths: _____

17. Symptom Checklist

1. Depressed Mood: *Over the last 2 weeks, how often have you been bothered by any of the following problems?* (PHQ-9)

	Not at all	Several days	More than ½ the days	Nearly every day
1. Little interest or pleasure in doing things	□	□	□	□
2. Feeling down, depressed, or hopeless	□	□	□	□
3. Trouble falling or staying asleep, or sleeping too much	□	□	□	□
4. Feeling tired or having little energy	□	□	□	□
5. Poor appetite or overeating	□	□	□	□
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	□	□	□	□
7. Trouble concentrating on things, such as reading the newspaper or watching television	□	□	□	□
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	□	□	□	□
9. Thoughts that you would be better off dead	□	□	□	□
10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	□ Not difficult at all □ Somewhat difficult □ Very difficult □ Extremely difficulty			

2. Elevated Mood (MDQ)

1. Has there ever been a period of time when you were not your usual self and…	No	Yes
…you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	□	□
…you were so irritable that you shouted at people or started fights or arguments?	□	□
…you felt much more self-confident than usual?	□	□
…you got much less sleep than usual and you found you didn't really miss it?	□	□
…you were much more talkative or spoke much faster than usual?	□	□
…thoughts raced through your head or you couldn't slow your mind down?	□	□
…you were so easily distracted by things around you that you had trouble concentrating or staying on track?	□	□
…you had much more energy than usual?	□	□
…you were much more active or did many more things than usual?	□	□
…you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	□	□
…you were much more interested in sex than usual?	□	□
…you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	□	□
…spending money got you or your family into trouble?	□	□
2. If you checked YES to more than one of the above, have several of these ever happened during the same time period?	□	□
3. how much of a problem did any of these cause you—like being unable to work; having family, money, or legal troubles; getting into arguments or fights?	□ No problem □ Minor problem □ Moderate problem □ Serious problem	
4. Have any of your blood relatives (i.e., children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	□	□
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	□	□

3. Generalized Anxiety:

Over the last two weeks, how often have you been bothered by the following problems? (GAD-7)

	Not at all	Several	More than	Nearly

		days	½ the days	every day
Feeling nervous, anxious or on edge	□	□	□	□
Not being able to stop or control worrying	□	□	□	□
Worrying too much about different things	□	□	□	□
Trouble relaxing	□	□	□	□
Being so restless that it is hard to sit still	□	□	□	□
Becoming easily annoyed or irritable	□	□	□	□
Feeling afraid as if something awful might happen	□	□	□	□

4. Other Anxiety: Please check any of the following you've experienced **in the last 3 months**.

	No	Yes
Feel fearful of leaving the house, being in public (e.g., standing in lines, take bus)	□	□
Avoid or reduce frequency of time away from home	□	□

	No	Yes
Feel anxious around others	□	□
Feel fearful of or embarrassed by being watched or the focus of attention	□	□
Feel anxious about doing things like writing, eating, or speaking in front of others	□	□
Avoid or suffer through situations involving others	□	□
Does this anxiety, fear, or embarrassment seem excessive or unreasonable?	□	□

	No	Yes
Sudden intense episodes of nervousness or panic	□	□
During these episodes do you experience: □ Racing heart □ Sweaty/clammy hands □ Trembling/shaking □ Dizziness □ Difficulty breathing □ Choking sensation □ Chest pressure □ Nausea □ Tingling/numbness □ Fear of losing control/dying □ Sense of being out of body		

	No	Yes
Bothered by thoughts, impulses, or images that cause anxiety and are difficult to shut out	□	□
Bothered by awful thoughts (e.g., accidently hurting others, being contaminated by germs)	□	□
Difficulty resisting doing certain unusual things (e.g., counting to certain numbers, washing hands)	□	□

5. Traumatic Stress: *Please check any of the following you've experienced **in the last 3 months**.*

	No	Yes
Is there a traumatic event or memory that comes back in nightmares, flashbacks, or thoughts?	□	□
Do you avoid situations or cues that remind you of the traumatic event event?	□	□
Since the event, are you jumpy, prone to angry outbursts, or having difficulty falling/staying asleep?	□	□

6. Non-Ordinary Experiences: *Please check any of the following you've experienced **in the last 3 months**.*

	No	Yes
Hear or see things that others do not hear or see	□	□
Receive special messages from people, circumstances, the way things were arranged or the radio/TV.	□	□

7. Difficulties with Food: *Please check any of the following you've experienced **in the last 3 months**.*

	No	Yes
Weighing much less than others thought you should	□	□
Afraid of gaining weight and restricting your food intake to prevent weight gain	□	□
Experience a time when your eating was out of control	□	□
Made yourself throw up, used laxatives, or exercised in excess to make up for having eaten too much	□	□

8. Dissociation: *Please check any of the following you've experienced **in the last 3 months**.*

	No	Yes
Feel as though you are not in your body	□	□
Loose track of extended periods of time	□	□
Feel as though things were not real or as if you were in a dream	□	□

9. Difficulties with Attention: *Please check any of the following you've experience **in the last 3 months**.*

	No	Yes
Difficulty concentrating or paying attention to detail for at least 6 months or longer	□	□

Felt or were told you were hyperactive, impulsive, or too restless	□	□
Have a hard time getting things done or attempting to do too much at once	□	□
Do you find these difficulties make work, school, or other obligations very difficult?	□	□
Do you find your emotions change quickly from minute to minute depending on what is happening?	□	□
Were you diagnosed with ADD/HD as a child or did you experience symptoms of ADD/HD as a child?	□	□

10. Alcohol Use *(CAGE)*

	No	**Yes**
Have you ever felt the need to cut down on your drinking?	□	□
Do you feel annoyed by people complaining about your drinking?	□	□
Do you ever feel guilty about our drinking?	□	□
Do you ever drink an "eye-opener" in the morning to relieve your nerves or get over a hangover?	□	□

At their worst, how bad do the above symptoms get?

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For Office Use Only ~ ***General Notes***

Fee agreement: $_____/session	☐ Informed consent, limits of confidentiality, and practice policies reviewed. Date received: _____	☐ HIPAA receipt received. Date received: _____