Please print clearly. If any question is difficult for you to answer, please let me know.

Full Name: _____ Preferred Name: _____ Gender: _____

Address: _____ City: _____ Zip: _____

Birthdate: _____ Age: ____ Phone Number: _____ ☐ Cell ☐ Work ☐ Home

Who lives with you (*check all that apply*)? ☐ Just me ☐ Spouse/Partner ☐ Boyfriend/Girlfriend

☐ Children (# __) ☐ Parent(s)/In-law(s) ☐ Roommate(s) ☐ Pet(s) ☐ Other: _____

Emergency contact: _____ _____ _____
Name Relationship Phone no.

Please tell me why you made an appointment to see me: _____

_____

How did you find me? ☐ Online Directory/Search ☐ Website ☐ Friend/Family ☐ Other: _____

Name: _____ May I thank them for their referral? ☐ Yes ☐ No

Highest education completed? ☐ 10 ☐ 11 ☐ 12 ☐ GED ☐ Any college ☐ AA ☐ BA/BS ☐ Post-Grad

Current relationship status: _____ For how long? _____

How content are you with your relationship status? _____

Current occupation: _____ ☐ Full-time ☐ Part-time Since _____

How content are you in your occupation? _____

Do you have a Primary Care Physician? ☐ Yes ☐ No When did you last see a doctor? _____

Name: _____ Phone: _____ Address: _____

Are you currently receiving medical treatment? ☐ No ☐ Yes Details: _____

What medications/supplements are you taking? _____

Have you seen a therapist, psychologist, or psychiatrist before? ☐ No ☐ Yes When? _____

If yes, for what purpose/concern? _____

Have you ever been prescribed medication for a mental health concern? ☐ No ☐ Yes

If yes, please describe: _____

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Any suicidal thoughts today? ☐ Yes ☐ No In the past? ☐ Yes ☐ No Ever attempted suicide? ☐ Yes ☐ No

Have you physically hurt yourself or others? ☐ No ☐ Yes Details: _____

Has anyone physically hurt you in the past year? ☐ Yes ☐ No Do you currently feel safe? ☐ No ☐ Yes

Details: _____

I use alcohol: ☐ Never ☐ Rarely ☐ Once a month or more ☐ Once a week or more ☐ Daily

I use drugs: ☐ Never ☐ Rarely ☐ Once a month or more ☐ Once a week or more ☐ Daily

Does your alcohol and/or drug use cause problems at home, at work, or socially? ☐ Yes ☐ No

Please check the boxes below if you have had problems or concerns with any of the following:

Aggressiveness	☐ Present	☐ Past	Legal worries	☐ Present	☐ Past
Aging-related issues	☐ Present	☐ Past	Impulsive Behavior	☐ Present	☐ Past
Alcohol use	☐ Present	☐ Past	Loneliness	☐ Present	☐ Past
Anger	☐ Present	☐ Past	Loss of control	☐ Present	☐ Past
Anxiety	☐ Present	☐ Past	Memory issues	☐ Present	☐ Past
Apathy	☐ Present	☐ Past	Monogamy/Non-monogamy	☐ Present	☐ Past
Bad dreams	☐ Present	☐ Past	Nervousness	☐ Present	☐ Past
Changes in appetite	☐ Present	☐ Past	Pain	☐ Present	☐ Past
Communication	☐ Present	☐ Past	Panic	☐ Present	☐ Past
Decision-making	☐ Present	☐ Past	Parenting issues	☐ Present	☐ Past
Depression	☐ Present	☐ Past	Physical abuse	☐ Present	☐ Past
Difficulty breathing	☐ Present	☐ Past	Racing thoughts	☐ Present	☐ Past
Digestive upset	☐ Present	☐ Past	Rapid heart rate	☐ Present	☐ Past
Divorce/Separation	☐ Present	☐ Past	Relationship issues	☐ Present	☐ Past
Dizziness	☐ Present	☐ Past	Sadness	☐ Present	☐ Past
Drug use	☐ Present	☐ Past	Seeing things	☐ Present	☐ Past
Eating issues	☐ Present	☐ Past	Serious illness	☐ Present	☐ Past
Emotional abuse	☐ Present	☐ Past	Sexual abuse	☐ Present	☐ Past
Emotional instability	☐ Present	☐ Past	Sexual concerns	☐ Present	☐ Past
Fatigue	☐ Present	☐ Past	Stress	☐ Present	☐ Past
Fear	☐ Present	☐ Past	Trauma	☐ Present	☐ Past
Fertility/Infertility	☐ Present	☐ Past	Trouble focusing	☐ Present	☐ Past
Fidelity/Infidelity	☐ Present	☐ Past	Trouble relaxing	☐ Present	☐ Past
Financial worries	☐ Present	☐ Past	Trouble sleeping	☐ Present	☐ Past
Grief/Loss	☐ Present	☐ Past	Unhappiness	☐ Present	☐ Past
Guilt	☐ Present	☐ Past	Unwanted thoughts	☐ Present	☐ Past
Headaches	☐ Present	☐ Past	Verbal abuse	☐ Present	☐ Past
Hearing noises/voices	☐ Present	☐ Past	Withdrawal/Isolation	☐ Present	☐ Past
Hopelessness	☐ Present	☐ Past	Work worries	☐ Present	☐ Past

Anything else you would like me to know? _____

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