Demographic Information

Name: _____ DOB: _____

Address: _____

_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

★ Can information be emailed to you? Yes _____ (Initials) No _____ (Initials)

If so, provide email address: _____

★ Can information be mailed to you at the above address? Yes _____ (Initials) No _____ (Initials)

★ Can messages be left at the above phone numbers? Yes _____ (Initials) No _____ (Initials)

If no, do you have an alternate phone number: _____

Spouse/Partner: _____ DOB: _____

Duration of Marriage: _____ Previous Marriages: Yes No

Children and/or other household members (names and DOB): _____

_____

_____

Education Level/Degrees Held: _____

Occupation: _____ Employer: _____

Religious/Spiritual Affiliation or Beliefs: _____

In case of emergency, contact: _____
Name and Relation

_____
Phone Number

Physician: _____ Phone: _____

Date of last physical exam: _____ Health Problems: _____

_____

_____

Mental Health Information

What brings you in today: _____

_____

_____

_____

What do you wish to accomplish throughout the course of therapy: _____

_____

_____

_____

Do you currently experience, or have you experienced in the past 6 months, any of the following:

____Irritability	____Fatigue	____Poor Concentration	____Restlessness
____Change in sleep	____Weight gain or loss	____Excessive Guilt	____Excessive worry
____Diminished self esteem	____Change in appetite	____Hopelessness	____Tension
____Nightmares	____Bedwetting	____Nervousness	____Stress
____Unhappiness	____Headaches	____Health problems	____Sexual problems
____Loneliness	____Depression	____Fears	____Intrusive thoughts
____Hallucinations	____Low self-concept	____Indecisiveness	____Confusion

Have you ever had thoughts of suicide? Yes No Most recent: _____

Have you ever attempted suicide? Yes No Date(s): _____

Are you currently having suicidal thoughts? Yes No

Previous mental health treatment (list treating practitioner, dates, and reason for treatment): _____

_____

_____

Are you taking any medications (list): _____

_____

Prescribed by: _____

Mental Health Information (cont.)

How often do you use alcohol (circle): Special occasions only _____x per month

_____x per week Daily

How many drinks do you have: _____

How often do you use other substances (list): _____

_____

Family History

Is there any history of mental illness, suicide attempts, or substance abuse by parents, siblings, or close relatives:

	Mood Disorder (depression, bipolar)	Anxiety	Suicide Attempts	Substance Abuse	Schizophrenia	Other
Father	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐
Siblings	☐	☐	☐	☐	☐	☐
Close Relative	☐	☐	☐	☐	☐	☐

Referral Source: _____

May I thank them for the referral? Yes _____ (Initials) No _____ (Initials)

I hereby consent and authorize to have this therapist make any and all insurance claims on my/our behalf. I understand that all questions concerning insurance reimbursement and financial responsibility are to be discussed with my therapist.

Signature:_____ Date:_____