



Please provide the names and ages of the children in your family/household.

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Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

- No
- Yes, previous therapist/practitioner: \_\_\_\_\_

Are you currently taking any prescription medication?

- Yes
- No

Please list:

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Have you ever been prescribed psychiatric medication?

- Yes
- No

Please list and provide dates:

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## **GENERAL HEALTH AND MENTAL HEALTH INFORMATION**

1. How would you rate your current physical health? (please circle)

Poor      Unsatisfactory      Satisfactory      Good      Very good  
Please list any specific health problems you are currently experiencing:

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2. How would you rate your current sleeping habits? (please circle)

Poor      Unsatisfactory      Satisfactory      Good      Very good  
Please list any specific sleep problems you are currently experiencing:

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3. How many times per week do you generally exercise? \_\_\_\_\_

What types of exercise to you participate in:

\_\_\_\_\_

4. Please list any difficulties you experience with your appetite or eating patterns.

\_\_\_\_\_

5. Are you currently experiencing overwhelming sadness, grief or depression?

- No
- Yes

If yes, for approximately how long? \_\_\_\_\_

6. Are you currently experiencing anxiety, panic attacks or have any phobias?

- No
- Yes

If yes, when did you begin experiencing this? \_\_\_\_\_

7. Are you currently experiencing any chronic pain?

- No
- Yes

If yes, please describe? \_\_\_\_\_

8. Do you drink alcohol more than once a week?  No  Yes

9. How often do you engage recreational drug use?  Daily  Weekly  Monthly  
 Infrequently  Never

10. Are you currently in a romantic relationship?  No  Yes

If yes, for how long? \_\_\_\_\_

On a scale of 1-10, how would you rate your relationship? \_\_\_\_\_

11. What significant life changes or stressful events have you experienced recently:

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**FAMILY MENTAL HEALTH HISTORY:**

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	<u>Please Circle</u>	<u>List Family Member</u>
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

1. Are you currently employed?  No  Yes

If yes, what is your current employment situation:

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Do you enjoy your work? Is there anything stressful about your current work?

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2. Do you consider yourself to be spiritual or religious?  No  Yes

If yes, describe your faith or belief:

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3. What do you consider to be some of your strengths?

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4. What do you consider to be some of your weakness?

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5. What would you like to accomplish out of your time in therapy?

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6. What is the most important thing you think "this Therapist" should know about your concerns:

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