**Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.**

**Please fill out this form and bring it to your first session.**

|  |  |
| --- | --- |
| **Date** | Click here to enter a date. |

|  |  |  |
| --- | --- | --- |
| **Last Name** | **First Name** | **Middle Initial** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |

|  |  |
| --- | --- |
| **Birth Date** | **Age** |
| Click here to enter a date. | Click here to enter text. |

|  |  |
| --- | --- |
| **Gender** | **Marital Status** |
| Choose an item. | Choose an item. |

|  |  |
| --- | --- |
| **Street Address:** | Click here to enter text. |
| **Suite/Apt/Unit:** | Click here to enter text. |
| **City:** | Click here to enter text. |
| **State:** | Click here to enter text. |
| **Zip Code:** | Click here to enter      t     ext |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Home Phone:** | 000-000-000 | May we leave a message? | Yes ☐ | No ☐ |
| **Cell Phone:** | 000-000-000 | May we leave a message? | Yes☐ | No☐ |
| **Alternate Phone:** | 000-000-000 | May we leave a message? | Yes☐ | No☐ |
| **Email:** | Click here to enter text. | May we email you? | Yes☐ | No☐ |
| **Alternate Email:** | Click here to enter text. | May we email you? | Yes☐ | No☐ |

**Emergency Contact**:

|  |  |
| --- | --- |
| **Name:** | Click here to enter text. |
| **Phone:** | 000-000-000 |
| **Relationship:** | Click here to enter text. |

|  |  |
| --- | --- |
| **Medicaid** | **Medicaid ID Number** |
| **YES**☐ | Click here to enter text. |
| **NO☐** |  |

|  |  |
| --- | --- |
| **Name of Insurance Carrier (EAP)** | Click here to enter text. |
| **Member ID Number/Referral #** | Click here to enter text. |
| **Group ID Number** | Click here to enter text. |
| **Employer (Company Name )** | Click here to enter text. |

**Please list any children (if applicable):**

|  |  |
| --- | --- |
| **Name (First, Last)** | **AGE** |
| 1.Click here to enter text. | Click here to enter text. |
| 2.Click here to enter text. | Click here to enter text. |
| 3.Click here to enter text. | Click here to enter text. |
| 4.Click here to enter text. | Click here to enter text. |
| 5.Click here to enter text. | Click here to enter text. |
| 6.Click here to enter text. | Click here to enter text. |
| 7.Click here to enter text. | Click here to enter text. |
| 8.Click here to enter text. | Click here to enter text. |

Click here to enter text.

**Referred By (if applicable):**

**Have you previously received any type of mental health services?**

**No ☐Yes☐**

|  |
| --- |
| **Name of previous therapist/ practitioner:** |
| Click here to enter text. |

**Are you currently taking any prescription medication?**

**Yes ☐ No ☐**

**Please list prescription medication (s):**

|  |
| --- |
| Click here to enter text. |
| Click here to enter text. |
| Click here to enter text. |
| Click here to enter text. |
| Click here to enter text. |
| Click here to enter text. |
| Click here to enter text. |
| Click here to enter text. |

**YOURHEALTH INFORMATION**

1. **How would you rate your current physical health?**

**Poor ☐ Good☐ Very Good ☐**

1. **How would you rate your sleeping habits?**

**Poor ☐Good ☐Very Good ☐**

**Please describe any specific sleeping problems that you are currently experiencing:**

Click here to enter text.

1. **How many times per week do you generally exercise?**

**☐1☐2☐3 or more**

**What type of exercise do you participate in?**

Click here to enter text.

1. **Please describe any difficulties that you experience with your appetite or eating patterns:**

Click here to enter text.

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

**☐ No**

**☐ Yes**

|  |
| --- |
| Click here to enter text. |

**If yes, for approximately how long?**

1. **Are you currently experiencing anxiety, panic or phobias?**

**☐ No**

**☐Yes**

|  |
| --- |
| Click here to enter text. |

**If yes, when did you begin experiencing this?**

1. **Are you currently experiencing any chronic pain?**

**☐ No**

**☐ Yes**

**If yes, please describe:**

Click here to enter text.

1. **Do you drink alcohol more than once weekly?**

**☐ No ☐ Yes**

1. **How often do you engage in recreational drug use?**

**☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never**

1. **Are you currently in a romantic relationship?**

**☐ No☐ Yes**

**If yes, for how long?**

|  |
| --- |
| Click here to enter text. |

**On a scale of 1 to 10, how would you rate your relationship?**

Choose an item.

1. **What significant life changes or stressful events have you experienced recently?**

Click here to enter text.

**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.)**

|  |  |  |
| --- | --- | --- |
| **Behavior/ Condition** | **History** | **Relationship** |
| **Alcohol/ Substance Abuse** | **☐Yes☐ No** | Click here to enter text. |
| **Anxiety** | **☐ Yes ☐No** | Click here to enter text. |
| **Domestic Violence** | **☐ Yes ☐ No** | Click here to enter text. |
| **Eating Disorders** | **☐ Yes ☐ No** | Click here to enter text. |
| **Obesity** | **☐ Yes ☐ No** | Click here to enter text. |
| **Obsessive Compulsive Behavior** | **☐ Yes ☐ No** | Click here to enter text. |
| **Schizophrenia** | **☐ Yes ☐ No** | Click here to enter text. |
| **Suicide Attempts** | **☐ Yes☐ No** | Click here to enter text. |

**ADDITIONAL INFORMATION**

1. **Are you currently employed?☐No ☐ Yes**

**If yes, please briefly describe your employment?**

Click here to enter text.

**Do you enjoy your work? Is there anything that is stressful about your work?**

Click here to enter text.

1. **Do you consider yourself to be spiritual or religious?**

**☐No ☐ Yes**

**If yes, please describe your faith or belief?**

Click here to enter text.

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

Click here to enter text.

1. **What do you consider to be some of your weaknesses?**

Click here to enter text.

1. **What would you like to accomplish from therapy?**

Click here to enter text.