

Are you currently receiving psychiatric services, professional counseling or therapy elsewhere?

yes no If yes, where? _____

Have you had previous psychiatric services, professional counseling or therapy? yes no

If yes, please provide previous therapist's name: _____

Are you currently taking any prescribed psychiatric medications (i.e. antidepressant?) yes no

If yes, please list current medications and dosage: _____

If no, have you been previously prescribed psychiatric medications? yes no

If yes, please list: _____

When was your last visit to a health care provider? Date: _____

Doctor's name and phone number: _____

HEALTH AND SOCIAL INFORMATION

How would you describe your current physical health?

Poor Unsatisfactory Satisfactory Good Very Good

Please list any persistent physical symptoms or health concerns (i.e. chronic pain, headaches, hypertension, asthma, diabetes, vision or hearing problems). _____

Are you having difficulties with your sleeping habits? yes no

If yes, check where applicable:

sleeping too little sleeping too much poor sleep quality
 Difficulty falling or staying asleep Waking up too early
 Nightmares or distressing dreams Other _____

How many times per week do you exercise? _____

What type of exercise do you do? _____

Any changes/problems with appetite or eating habits? yes no

If yes, check where applicable:

Eating less Eating more Binging Restricting

Have you experienced significant weight change in the last 2 months? yes no

Have you ever used drugs or alcohol? yes no

If yes, please describe:

Substance Amount Frequency (i.e. daily, weekly) Last Use:

Have you ever experienced any of the following? (Please check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Extreme depressed mood | <input type="checkbox"/> Wild Mood Swings |
| <input type="checkbox"/> Rapid Speech | <input type="checkbox"/> Racing Thoughts |
| <input type="checkbox"/> Hallucinations (auditory, visual, tactile) | <input type="checkbox"/> Delusions |
| <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Frequent Body Complaints |
| <input type="checkbox"/> Repetitive Thoughts (i.e. Obsessions) | <input type="checkbox"/> Repetitive Behaviors (i.e. hand washing) |
| <input type="checkbox"/> Suicidal Thoughts/Thoughts of Self-Harm | <input type="checkbox"/> Homicidal Thoughts |

Please indicate which of the following issues/problems you would like to address in therapy:

- | | |
|--|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lack of friends |
| <input type="checkbox"/> Anxiety/Panic Attacks | <input type="checkbox"/> Grief/Loss |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Problems at School |
| <input type="checkbox"/> Phobias | <input type="checkbox"/> Problems at Work |
| <input type="checkbox"/> Sleep Disturbance | <input type="checkbox"/> Family Conflict |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Alcohol/Substance Abuse |
| <input type="checkbox"/> Traumatic Event | <input type="checkbox"/> Victim of Abuse (physical or sexual) |
| <input type="checkbox"/> Other: _____ | |

FAMILY MEDICAL/PSYCHIATRIC INFORMATION

Has anyone in your family had a serious medical condition? yes no

If yes, please explain: _____

Has anyone in your family (immediate or close relatives) experienced difficulties with the following?

Please check all that apply and list family member (i.e. sibling, parent, maternal aunt):

Difficulty:	Family Member	
Depression	<input type="checkbox"/> yes	<input type="checkbox"/> no
Bipolar Disorder	<input type="checkbox"/> yes	<input type="checkbox"/> no
Anxiety Disorders	<input type="checkbox"/> yes	<input type="checkbox"/> no
Panic Attacks	<input type="checkbox"/> yes	<input type="checkbox"/> no
Schizophrenia	<input type="checkbox"/> yes	<input type="checkbox"/> no
Alcohol/Substance Abuse	<input type="checkbox"/> yes	<input type="checkbox"/> no
Eating Disorders	<input type="checkbox"/> yes	<input type="checkbox"/> no
Learning Disabilities	<input type="checkbox"/> yes	<input type="checkbox"/> no
ADHD	<input type="checkbox"/> yes	<input type="checkbox"/> no
Trauma History	<input type="checkbox"/> yes	<input type="checkbox"/> no
Suicide Attempts	<input type="checkbox"/> yes	<input type="checkbox"/> no

OCCUPATIONAL /SCHOOL INFORMATION

Are you currently a student? yes no

If yes, school's name and current grade: _____

Are you currently employed? yes no

If yes, what is your current position? _____

Please list any school/work-related stressors: _____

If there is anything you think would be important for me to know that I did not ask about, please

write it here: _____
