



**Briefly describe your goals for therapy:** \_\_\_\_\_

\_\_\_\_\_

**How long have you had this problem? Have any recent events made this problem worse?**

\_\_\_\_\_

\_\_\_\_\_

**Mental Health Background**

**List any psychotropic medications (medications for your nerves) that you are taking.**

Medication	Dose/Frequency	When Started	For What Symptom(s)?

**List any previous mental health or substance abuse treatment (include any inpatient or hospital treatment for a mental health or substance abuse disorder) that you have had.**

Date of Treatment (approximate)	Name of Treatment Provider or Agency	What Was Your Problem at the Time?	Were Your Treatment Goals Met?

Was anything in your previous treatment particularly helpful? Not helpful? \_\_\_\_\_

\_\_\_\_\_

**At this time do you ever have thoughts of harming yourself? YES \_\_\_\_\_ NO \_\_\_\_\_**

**Have you ever attempted suicide? YES \_\_\_\_\_ NO \_\_\_\_\_**

**At this time do you ever have thoughts of harming others? YES \_\_\_\_\_ NO \_\_\_\_\_**

**Social History**

**Education (please circle)**

Did Not Finish High School                      High School                      Some College  
College    Graduate or Professional School

Occupation \_\_\_\_\_

**Current (or Past) Employer (or School)** \_\_\_\_\_

How long have you worked there (or did you work there)? \_\_\_\_\_

Describe your religious or spiritual orientation? \_\_\_\_\_

If you have a religion, how often do you attend religious services? (Circle one)

At least weekly              monthly              several times a year              once a year or less

Which of the following statements best describe you (check all that apply)

- \_\_\_\_\_ I have a lot of friends with whom I can confide in or count on
- \_\_\_\_\_ I have many close family members with whom I can confide in or count on
- \_\_\_\_\_ I have a few close friends with whom I can confide in or count on
- \_\_\_\_\_ I have a few close family members with whom I can confide in or count on
- \_\_\_\_\_ I have a lot of friends, but I can't confide in them or count on them
- \_\_\_\_\_ I have few friends and none whom I can confide in or count on

Would you say that you are lonely?

\_\_\_\_\_ frequently              \_\_\_\_\_ occasionally              \_\_\_\_\_ sometimes              \_\_\_\_\_ rarely

**Does your family have a history of mental illness or substance abuse? If so, please explain the nature of the problem, treatment they received and indicate if any particular medication was helpful.**

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### Legal History

Legal Event		If Yes, please give a brief description
Have you ever been arrested?	YES	_____
	NO	_____
Have you ever been arrested for a DUI (Drinking under the influence?)	YES	_____
	NO	_____
Have you ever been in prison?	YES	_____
	NO	_____
Are you currently involved in any litigation?	YES	_____
	NO	_____

### Medical Information

Name of primary care physician or provider \_\_\_\_\_

**Do I have your permission to send basic information (presenting problem, summary of treatment, relevant health information, etc.) to your primary care provider?**

YES \_\_\_\_\_ NO \_\_\_\_\_

**If yes, you will need to sign a specific “authorization” or “release of information form” in order for me to contact your primary care provider.**

How would you describe your physical health?

\_\_\_ excellent \_\_\_ good \_\_\_ average \_\_\_ poor \_\_\_ very poor

**List any medical conditions that you have.**

Medical condition or symptoms	Treatment (s)

**List any prescription medications that you take.**

Drug	Dose/Frequency	When Started	For What Symptom(s)?


**List any non prescription (over-the-counter) medications that you take?**

<b>Drug</b>	<b>Dose/Frequency</b>	<b>When Started</b>	<b>For What Symptom(s)?</b>

**Do you have any allergies or sensitivities to drugs, foods, or other substances?**

YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, please indicate the substances that you are allergic to or have sensitivities to:

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**Do you smoke or use other tobacco products? YES \_\_\_\_\_ NO \_\_\_\_\_**

If yes, please indicate what you smoke (or chew) and how much you smoke or chew in an average day.

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**Do you drink alcohol?** YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, please indicate what you drink and how much you drink in an average day.

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**Do you use recreational drugs such as marijuana, cocaine, or other drugs?**

YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, please indicate what you use how much you use in an average week.

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Do you take any over the counter medications more often than is recommended?

YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, please indicate what you use how much you use in an average week.

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**Describe your strengths or weaknesses**

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Is there any other information that would be useful to know about you?

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