Demographic Information

1/8

Date: _____ DOB: _____ Age: _____ Gender: _____

How do you identify? _____ What name do you prefer?_____
(LGBTQ, hetero, non-conforming, polyamorous, etc)

Physical Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone
Number(s):(mobile)_____(landline)_____
Is it ok to leave a voicemail? ○ *YES* ○ *NO*

Email: _____
Would you like to receive email communication? ○ *YES* ○ *NO*

Is it ok to send something via postal service? ○ *YES* ○ *NO*

Mailing Address: (if different) _____

City: _____ State: _____ Zip Code: _____

How were you introduced to me? _____

How Have We Come to Meet?

What are the 3 biggest concerns you have right now? How long have each been going on? Put them in order of importance:

1. _____
2. _____
3. _____

What do you think those that care about you would say their concern(s) is/are in regards to you?

_____
_____

What solutions (helpful or unhelpful) have you tried to resolve your concerns?

_____
_____

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** Updated 4/2018, 6/2019*

Have you had therapy in the past? If so, with whom and when? What reasons did you attend therapy for? Please share with me about your experience. What was helpful? unhelpful?

_____
_____
_____

Change is Coming…

What are your expectations from therapy? What are your expectations of the therapist?

_____
_____
_____

Looking into the future, how will you know that our work and time together has been sucessful? List concrete changes you will see:

_____
_____
_____

What other things would you like to see change in your life (family, career, health, relationships, etc.)?

_____
_____
_____

Do you foresee any obstacles to achieving your goals or the desired changes?

_____
_____

How long do you think therapy will need to last to achieve your goals? Write down a target date:

_____

List 3-5 strengths about yourself or that others say about you, give examples of each:

1. _____
2. _____
3. _____
4. _____
5. _____

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Is there anyone that you would like to invite to be a part of your sessions or think may be helpful to be part of sessions either now or in the future? Please share reasons:

_____

_____

Medical & Wellness Information

What do you do for wellness (i.e. healthy food choices, exercise, limits on TV/electronics/work, managing stress, family time, leisure, etc.)? Give examples:

_____

_____

How do you achieve balance in your life?

_____

_____

Have you ever received psychiatric services before? ○ YES ○ NO

If yes, how long ago, with whom, for what, medications prescribed and results:

_____

_____

_____

_____

Do you have any allergies (food, environmental, medicinal, animal, etc.)

_____

_____

Do you have any current <u>or past</u> medical issues, hospitalizations, accidents, injuries or surgeries? If yes, what?

_____

_____

_____

_____

Is there a family history of the above medical issues/concerns?

_____

_____

Are you presently under a physician's/psychiatrist's care? If so, for what reason?

_____

_____

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Is there anyone in your life that is currently dealing with a medical issue that you are concerned about? If so, whom, for what?

_____

_____

In the past year, have there been any changes in your life? (i.e.: moves, work, losses, changes in appetite, sleep, health, family, overall functioning)?

_____

_____

_____

List any medications (over-the -counter & prescribed), nutritional or herbal supplements, or alternative treatments (acupuncture, chiropractic, etc.) you are taking/doing and the reasons:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Important Safety Questions To Ask

Have you ever had thoughts of killing yourself? ○ YES ○ NO
If yes, please explain when, and what was occurring:

_____

_____

Have you ever planned on killing yourself? ○ YES ○ NO
If yes, please explain:

_____

_____

Have you ever attempted to kill yourself? ○ YES ○ NO
If yes, please explain:

_____

_____

Do you feel safe at home, in your community, at work? ○ YES ○ NO
Specify concerns:_____

_____

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Has anyone in your family or close to you died by suicide? ○ YES ○ NO
If yes, please share:

Have you ever felt you wanted to seriously harm or kill someone else? ○ YES ○ NO
If yes, please share:

Do you have weapons in your home or access to weapons? ○ YES ○ NO
If yes, who has access to them and what are the safety protocols around them?

Is there any history or presence of abuse or violence? ○ YES ○ NO
If so, please share who, what, & when:

Are you currently using any illegal drugs or prescription medications in a way other than was prescribed, or is part of the reason you are seeking therapy services substance related?

Have you ever witnessed or experienced a trauma? Do you have reoccurring nightmares, flashbacks, or do you avoid anything that is uncomfortable or painful? If so, please explain:

Do you have currently legal issues or is the reason you are seeking therapy related to a court order? If so, please explain:

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Career/Job, Recreation and Leisure **6/8**

Are you employed? ○ YES ○ NO If yes, what is your current occupation? How would you describe your fulfillment of your job/career? If no, how do you spend your days – activities, amount of structure, etc?

_____
_____
_____

What is your highest level of education completed and field of study?

_____
_____

What do you enjoy doing during your free/leisure time?

_____
_____

Typically, estimate how many hours/day do you spend viewing electronic screens? _____

Intimate Relationships

If you are currently in one or more committed relationship(s), describe your relationship(s):

_____
_____
_____

How would you describe your communication in your primary relationship?

_____
_____

How would you describe the quality and safety of intimacy and/or sex in your relationships?

_____
_____
_____

- If you are in a primary relationship answer the following regarding your relationship:

  1. Like _____
  2. Dislike _____
  3. Not enough of _____
  4. Too much of _____
  5. Ideal relationship _____

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Understanding Your Family & Influences

** Space left for therapist to draw family tree (genogram)*

Parent's marital status:

○ Married ○ Divorced ○ Never Married ○ Separated ○ Domestic Partners ○ Widowed

Please describe your relationship with your parents:

_____

_____

How would you describe your upbringing?

_____

_____

Who lives with you currently?

_____

_____

Do you have any pets? If yes, names, types and relationship to each pet:

_____

_____

Describe your relationship with the following:

Mother:

_____

Father:

_____

Mother's Significant Other:

_____

Father's Significant Other:

_____

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Siblings: Age, Name and Gender: **8/8**

Sibling 1 _____

Sibling 2 _____

Sibling 3 _____

Sibling 4 _____

Sibling 5 _____

Sibling 6 _____

Children: Age, Name, Gender

a. Child 1 _____

b. Child 2 _____

c. Child 3 _____

Significant Others/Spouses (Age, Name, Gender, length of time together)

_____

_____

Relationships

Describe your relationship with your friends:

_____

_____

Who/what would you say your main support system is (people, organizations, or affiliations)?

_____

_____

Do you belong to any religious or spiritual groups? ○ YES ○ NO

If yes, what is your level of involvement?

_____

How do your religious or spiritual beliefs/practices influence your life?

_____

_____

Please list anything else that is important for us to know about you that would assist us in working with you to achieve your desired results:

_____

_____

_____

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