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Today's Date:_____

Name_____ Date of Birth_____ Age_____

Address_____

Work phone (_____)_____ Home phone (_____)_____

Cell phone (____)_____ Email_____

Occupation_____ Employer_____

Employer's address _____

Referred by_____ Marital Status M S D W Other_____

With whom do you live?_____ _____

Any prior marriages? _____ If yes, when_____

Number of children (list names and ages) _____

_____

May I identify myself if I call your home? ____ yes ___ no

CONCERNS:

1. What is the major reason you are seeking help at this time?

2. How long have these things been bothering you? Did they start gradually or suddenly?

3. What do <u>you</u> think is causing the problem?

4. What have you tried to do so far? How has that worked?

5. What objective do you have <u>for yourself</u> as a result of being in therapy?

Have you been in therapy before? If so, when and with whom?

DATE	THERAPIST	LOCATION	LENGTH OF TREATMENT	TYPE OF TREATMENT	RESULTS

Check all items below that apply to your present condition:

- ☐ Headaches
- ☐ Dizziness
- ☐ Stomach trouble
- ☐ Bowel trouble
- ☐ Feel tense
- ☐ Irritable
- ☐ Unusual thoughts
- ☐ Strange experiences
- ☐ Weight change
- ☐ Always tired
- ☐ Can't go to sleep
- ☐ Can't stay asleep
- ☐ Other:
- ☐ Nightmares
- ☐ Sexual problems
- ☐ Financial problems
- ☐ Depressed
- ☐ Panicky feelings
- ☐ Tremors or tics
- ☐ Always worried
- ☐ Unable to relax
- ☐ Feel worthless
- ☐ Can't make decisions
- ☐ Thoughts of suicide
- ☐ Ready to explode
- ☐ Specific fear
- ☐ Unable to work well
- ☐ Can't get interested
- ☐ Drink excessively
- ☐ Excessive use of drugs
- ☐ Unable to have a good time
- ☐ Trouble concentrating
- ☐ Can't make friends
- ☐ Can't keep friends
- ☐ Feel apart from people
- ☐ Fear things I shouldn't
- ☐ Conflict within family
- ☐ Fear I will lose self-control
- ☐ Dissatisfied with sexual relationship

Medications used during the last year:_____

_____

Serious illnesses, surgeries, or medical conditions _____

_____

Do you drink alcohol? _____ Frequency and amount_____

Have you or a spouse or family member struck, physically restrained, used violence against, or injured the other person within the last few years? _____ If yes, how often, and what happened:

_____

_____