INFORMATION SHEET

Name_____
(Last) (First) (Middle Initial)

Birth Date: _____Age:_____Gender:_____

School: _____Occupation:_____ Highest Grade completed: _____

Marital Status:
( ) Never Married ( ) Partnered ( ) Married ( ) Separated ( ) Divorced ( ) Widowed

Names and birthdates of children: _____ _____

_____ _____ _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: _____Cell/Other Phone: _____

Where can I leave a message? _____

Referred by: _____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, high blood pressure, diabetes etc.)

3. Are you having any problems with your sleep habits? No Yes

If yes, circle where applicable:

Sleeping too little Sleeping too much Poor quality of sleep Disturbing dreams
Other_____

4. How many times per week do you exercise? _____

5. Are you having any difficulty with appetite or eating habits? No Yes

If yes, circle where applicable: Eating less, Eating more, Bingeing, Restricting

6. Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? _____

7. In a typical month, how often do you have 4 or more drinks in a 24 hour period?

8. How often do you engage recreational drug use? Daily Weekly Monthly

9. Have you had suicidal thoughts recently? Frequently Sometimes Rarely Never

10. Have you had them in the past? Frequently Sometimes Rarely Never

11. Are you currently in a romantic relationship? No Yes

    If yes, how long have you been in this relationship? _____

    On a scale of 1-10 how would you rate the quality of your current relationship? __

12. What do you do for fun?

13. What do you do for relaxation?

14. What do you do for connecting with people in your neighborhood or community?

15. Do you take prescription medication? If yes. Please list.

16. In the last year have you experienced any significant life changes or stressors? If yes, please explain:

    _____

    _____

Have you ever experienced?

Extreme depressed mood	yes/no
Wild Mood Swings	yes/no
Rapid Speech	yes/no
Extreme Anxiety	yes/no
Panic Attacks	yes/no
Phobias	yes/no
Sleep Disturbances	yes/no
Hallucinations	yes/no
Unexplained losses of time	yes/no
Unexplained memory lapses	yes/no
Alcohol/Substance Abuse	yes/no
Frequent Body Complaints	yes/no
Eating Disorder	yes/no
Body Image Problems	yes/no

OCCUPATIONAL INFORMATION:

Are you currently employed? No Yes

If yes, who is your current employer/position? _____

If yes, are you happy at your current position? _____

Please list any work-related stressors, if any: _____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? No Yes

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? No Yes

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Circle any that apply and list family member e.g. Sibling, Parent, Uncle, etc.):

Difficulty		**Family Member**
Depression	yes/no	
Bipolar Disorder	yes/no	
Anxiety Disorders	yes/no	
Panic Attacks	yes/no	
Schizophrenia	yes/no	
Alcohol/Substance Abuse	yes/no	
Eating Disorders	yes/no	
Learning Disabilities	yes/no	
Trauma History	yes/no	
Suicide Attempts	yes/no	

OTHER INFORMATION:

What do you consider to be your strengths?

What do you like most about yourself?

What are effective coping strategies that you've learned?

What do you like most about your children, spouse, or partner?

What do you like least about your children, spouse, or partner?

What are your goals for therapy?