Today’s date:

Your name: Date of birth: Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
Street address: Apt.: \_\_\_\_\_\_\_\_\_\_\_
City: State: OH Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Best Phone: e-mail:
Calls or e-mail will be discreet, but please indicate any restrictions:

Are you (circle one): Never Married x Married Separated Divorced

Are you (circle one): Working Unemployed Student In the Military On Disability Retired

Employer or School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title/ Role or Level in School: \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity/national origin: \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race: \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

**Chief concer**n: **Please describe the main difficulty that has brought you to see me**:

**What would you like to accomplish in therapy with me?**

**Your education and training**

How far did you go in school? ❑ High School/GED ❑ Associates ❑ Bachelors [ ]  Graduate Degree

❑ Specialized Training in \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Information**

Relationship First Name Age Education Occupation Living with you\_\_

 Yes No

Father \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Significant Others (siblings, grandparents,step or half-relatives, romantic partners)**

Relationship First Name Age Education Occupation Living with you

 Yes No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Present relationships**

1. How do you get along with your spouse or partner? (Or circle N/A)

2. How do you get along with your children? (Or circle N/A)

3. How do you get along with your friends? (please comment on good and bad parts of relationships)

**Relationships in your family of origin.** Please describe the following:

1. Your parents’ relationship with each other

2. Your relationship with each parent:

3.

4. Your relationship with your brothers and sisters, in the past and present:

**Treatment: H**ave you received counseling or psychotherapy before? (Please circle) No Yes

If yes, please indicate:

When/How Long? With whom? For what? With what results?\_\_\_\_\_\_\_\_\_\_

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever taken medications for mental health concerns? (Please circle) No Yes

If yes, please indicate current medications first:

When? From whom? Which medications? For what? With what results?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your medical care:** From whom or where do you get your primary medical care?

Clinic/doctor’s name: Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list current or past health problems:

1. \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I will not make contact with your physician unless you and I together agree that doing so will benefit therapy.

**Chemical use**

1. How much caffeine do you have per day

2. How much tobacco do you smoke or chew each week?

3. How much alcohol (beer, wine, hard liquor) do you consume each week?

4. How often do you use over the counter medications?

5. Do you ever take more than the recommended dose of any prescription drug? (Please circle) No Yes

Please explain:

6. Which illegal drugs you use? (please provide details such as amounts, how often you used them, their effects)

**Legal history:**

1**.** Are you involved in any legal issues at the present time?/Describe-

2. Have you had legal issues in the past that I should know about?

**Emergency information**

If some kind of emergency arises and I cannot reach you directly, or I need to reach someone close to you, whom should I call?

Name: \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have any members of your biological family (not you) had any of the following problems or disorders (check all that apply):

□ Birth Defect □ Cerebral Palsy □ Chromosome/Genetic Disorder

□ Physical Handicap □ Seizures/Epilepsy □ Tuberous Sclerosis

□ Severe Head Injury □ Autism/PDD □ Mental Retardation

□ Learning Disability □ Speech Language Delay □ Received Special Education

□ Food Allergies □ Migraines

□ Nervousness/Anxiety □ Depression □ Obsessive Compulsive Disorder

□ Bipolar-manic-depressive disorder □ Schizophrenia □ Emotional Disturbance

□ Tics/Tourettes syndrome □ ADHD

□ Childhood Behavior Disorder (aggressive/deviant/ADHD) □ Antisocial Behavior (assaults, theft, arrest)

□ Alcohol/Drug Abuse

□ Other Problems

Please indicate any major stressors that you are experiencing or have experienced within the last year:

□ Marital discord/fighting □ Separation □ Divorce

□ Birth/Adoption of child □ Sibling conflict □ Parent-child conflict

□ Custody disagreement □ Single-parent family □ Death of loved one

□ Partner deployed extensively □ Move □ Legal problems

□ Family emotionally/mentally ill □ Physical abuse □ Sexual abuse

□ Health problems □ Financial problems □ School stress

□ Parental disagreement about child-rearing □ Involved with Social Services/Child Protective Services

□ Other stress, if not listed:

Please describe stress listed above:

**Current Problem Checklist:** Please mark all of the items below that apply, and feel free to add any others at the bottom under “Any other concerns or issues.” You may add a note or details in the space next to the concerns checked.

❑ I have no problem or concern bringing me here

❑ Abuse—physical, sexual, emotional, neglect, cruelty to animals

❑ Aggression, violence

❑ Alcohol use

❑ Anger, hostility, arguing, irritability

❑ Anxiety, nervousness, tension

❑ Attention, concentration, distractibility

❑ Career concerns, goals, and choices

❑ Childhood issues (your own childhood)

❑ Confusion, disorganized thoughts

❑ Custody of children

❑ Decision making, indecision, mixed feelings, putting off decisions

❑ Delusions (false ideas)

❑ Dependence

❑ Depression, low mood, sadness, crying

❑ Divorce, separation

❑ Drug use—prescription medications, over-the-counter medications, street drugs

❑ Eating problems—overeating, undereating, appetite, vomiting (see also “Weight and diet issues”)

❑ Emptiness

❑ Failure

❑ Fatigue, tiredness, low energy

❑ Fears, phobias

❑ Financial or money troubles, debt, impulsive spending, low income -student loans and credit cards

❑ Friendships

❑ Gambling

❑ Grieving, mourning, deaths, losses, divorce

❑ Guilt

❑ Headaches, other kinds of pains

❑ Health, illness, medical concerns, physical problems--please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Inferiority feelings

❑ Interpersonal conflicts

❑ Impulsiveness, loss of control, outbursts

❑ Irresponsibility

❑ Judgment problems, risk taking

❑ Legal matters, charges, suits

❑ Loneliness

❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments

❑ Memory problems

❑ Menstrual problems, PMS, menopause

❑ Mood swings

❑ Motivation, laziness

❑ Obsessions, Compulsions (thoughts or actions that repeat themselves)

❑ Oversensitivity to rejection

❑ Pain, chronic

❑ Panic or anxiety attacks

❑ Parenting, child management, single parenthood

❑ Perfectionism

❑ Pessimism

❑ Procrastination, work inhibitions, laziness

❑ Relationship problems (with friends, with relatives, or at work)

❑ School problems

❑ Self-centeredness

❑ Self-esteem

❑ Self-neglect, poor self-care

❑ Sexual issues, dysfunctions, conflicts, desire differences, other (see also “Abuse”)

❑ Shyness, oversensitivity to criticism

❑ Sleep problems—too much, too little, insomnia, nightmares

❑ Smoking and tobacco use

❑ Spiritual, religious, moral, ethical issues

❑ Stress, relaxation, stress management, stress disorders, tension

❑ Suspiciousness, distrust

❑ Suicidal thoughts

❑ Temper problems, self-control, low frustration tolerance

❑ Threats, violence

❑ Weight and diet issues

❑ Withdrawal, isolating

❑ Work problems, employment, workaholism/overworking, can’t keep a job, dissatisfaction, ambition

❑ Other concerns or issues:

Please look back over the concerns you have checked off and choose the one that you most want help with. It is:

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms?

*Thank you very much for your time and patience in completing this form!*

*This information will be a great help to me in understanding your needs.*