CLIENT HISTORY

Please answer the following questions to the best of your knowledge.
Please note: information you provide here is protected as confidential information.

Name: _____

Address: _____

Home phone: _____ May I leave a message? _____

Cell phone: _____ May I leave a message? _____

email: _____ May I email you? _____

Referred by (if applicable): _____

Date of birth: _____

Marital status: Never married Domestic partnership Married

Separated Divorced Widowed

Please list any children/ages: _____

_____

Have you ever participated in psychotherapy before? _____ If yes, when? _____

_____

Have you ever had psychiatric services before? _____ If yes, when? _____

_____

Have you ever been hospitalized for a mental health reason? Dates?

_____

Have you ever had thoughts of suicide or attempted suicide? If yes, when?

_____

Have you ever had any serious illnesses? Seizures? Head injuries? If so, please list:
_____

_____

Do you have any current specific health concerns? Chronic pain? If so, please list:
_____

_____

Do you take any medications (prescription/psychiatric) at this time? If so, please list medications and doctor prescribing:
_____

_____

How would you rate your current physical health on a scale of 1-10? _____

Do you suffer from sleep problems? Please describe: _____

_____

Do you have any problems with eating or appetite? Please describe: _____

_____

How much do you exercise per week? _____

Are you currently in a relationship? _____How would you rate your relationship?

_____

Are you currently experiencing overwhelming depression or grief? If yes, for how long?

_____

Are you currently experiencing anxiety, panic attacks, or phobias? If yes, for how long?

_____

Have you ever struggled with substance abuse issues? If yes, when?

_____

Have you ever struggled with issues related to sexual orientation, gender identity, or gender dysphoria? _____

What significant life changes or stressful events have you experienced recently?

_____

_____

_____

Current issues I seek to address in psychotherapy include (check all that apply):

____ depression

____ anxiety

____ panic attacks

____ symptoms of trauma

____ self-injurious behavior (i.e. cutting, etc)

____ relationship issues

____ ADHD

____ behavioral problems (child/adolescent)

____ anger problems

____ communication problems

____ family dynamics

____ mood disorder

Family mental health history: Please list any family members that struggle with the following issues and their relationship to you (maternal aunt, paternal grandmother, etc).

	Please circle	**Family member**
Depression	yes/no	
Anxiety	yes/no	
Bipolar Disorder	yes/no	
Schizophrenia	yes/no	
Eating Disorder	yes/no	
Substance abuse	yes/no	
Domestic violence	yes/no	
Self-injurious behavior	yes/no	
Suicide attempt	yes/no	

Are you currently employed? _____ Occupation: _____

Do you enjoy your work? _____

Is there anything stressful about your work? _____

_____

With which cultural or ethnic group(s), if any, do you identify?

_____

Describe any issues/challenges you are experiencing related to cultural or ethnic issues:

_____

_____

Do you affiliate with any spiritual/religious group? _____

Please share any thoughts or information regarding your spiritual/religious beliefs that you feel it is important that I understand: _____

_____

What do you consider to be your strengths? _____

_____

_____

What do you consider to be your weaknesses? _____

_____

_____

What would you like to accomplish in your time in therapy? _____

_____

_____