



**EMERGENCY CONTACT INFORMATION**

*In case of emergency, I authorize the following person to receive notification:*

Emergency Contact: \_\_\_\_\_  
Name Relationship Phone

*I hereby authorize contact with this person, as specified above:*

\_\_\_\_\_  
Signature of Client

**PERSONAL HISTORY**

Please list any previous medical hospitalizations; serious illnesses, accidents, or injuries; seizures, head injuries, or other medical conditions: \_\_\_\_\_

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

Do you have any previous mental health diagnoses? If yes, please describe: \_\_\_\_\_

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

Have you ever been hospitalized for mental illness? If yes, please describe: \_\_\_\_\_

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

Have you ever attempted suicide or had serious thoughts of suicide? If yes, when and why? \_\_\_\_\_

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

Please list the mental health issues of **immediate and extended family members**, including Attention Deficit Disorder, learning disability, and “eccentricities:” \_\_\_\_\_

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

**CURRENT MEDICATIONS**

<i>Medication</i>	<i>Dose</i>	<i>Start Date</i>	<i>Symptoms Addressed</i>	<i>Prescriber</i>

**MEDICATION HISTORY**

<i>Medication</i>	<i>Dose</i>	<i>How helpful did you find the medication?</i>

**CURRENT SYMPTOMS** (Please check those that apply)

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depressed Mood
<input type="checkbox"/> Excessive and Persistent Worry	<input type="checkbox"/> Fatigue or Low Energy
<input type="checkbox"/> Difficulty Falling or Staying Asleep	<input type="checkbox"/> Difficulty Concentrating
<input type="checkbox"/> Change in Appetite or Weight	<input type="checkbox"/> Persistent Guilt
<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Unresolved Grief
<input type="checkbox"/> Phobias or Fears	<input type="checkbox"/> Irritability
<input type="checkbox"/> Social Anxiety	<input type="checkbox"/> Feeling Restless or On Edge
<input type="checkbox"/> Obsessive Thoughts	<input type="checkbox"/> Compulsive Behaviors
<input type="checkbox"/> Nightmares or Flashbacks	<input type="checkbox"/> Easily Distracted

**ALCOHOL & DRUG USE**

On average, how often do you use alcohol and/or other drugs?

- Never                       1 to 4 times per month       Daily  
 Less than once per month       1 to 5 times per week

Substance(s) and amount(s) consumed per occasion: \_\_\_\_\_

\_\_\_\_\_

Has your alcohol or drug use caused problems in your life? If yes, when and how? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you experienced problems with any other compulsive or difficult to control behaviors? Please describe briefly and indicate whether it is past or present: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SELF CARE**

What are the major stresses in your life? \_\_\_\_\_

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

What do you do to relax or relieve stress? \_\_\_\_\_

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

Who do you have in your life for emotional support? \_\_\_\_\_

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

How would you rate your eating habits?  Excellent  Good  OK  Fair  Poor

Do you have any sleep problems? \_\_\_\_\_

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

Do you exercise? How often and what type? \_\_\_\_\_

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

**COUNSELING HISTORY**

<i>Counselor</i>	<i>Dates</i>	<i>Reason(s)</i>

**COUNSELING GOALS**

Please describe the concern(s) for which you are currently seeking counseling: \_\_\_\_\_

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

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

What are your goals for counseling? \_\_\_\_\_

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

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