a lifetime to grow

Please fill out the entire form, answering as many questions as possible. Leave blank any that are unclear or that you want additional clarification on. Thank you.

General Information

Name: _____ Date of Birth: _____/_____/_____ Today's date: _____/_____/_____

Sex: Male _____ Female _____ SSN: _____ Home phone: (____) _____

Address:_____ City: _____ State: _____ Zip: _____

Work phone: (_____) _____ Cell phone: (____) _____ Email: _____

Ok to leave a message: Yes _____ No _____ On which phone? _____ Ok to send mail: Yes ____ No ____

Emergency contact/Relation: _____ Phone: (____) _____ Alt phone:(____)_____

My primary care provider: _____ Clinic name/phone: _____

Allergies: _____ Medical conditions: _____

Occupation: _____ Interests/hobbies: _____

I was referred by: _____

Insurance Information

Name of employer: _____ Insurance Provider: _____

Insurance phone: _____ Address: _____

ID#: _____ Group #: _____ Subscriber name: _____

Subscriber's birthdate: _____/_____/_____ Subscriber's address and phone if different from client: _____

_____

**A copy of your card will be made if you would like your insurance to be billed for reimbursement.

Relationship/Family Information

Relationship status (circle one): single married divorced cohabiting widowed separated

Sexual orientation (circle one): straight gay lesbian bisexual questioning

Name of spouse/partner if applicable: _____ Length of relationship: _____ Separations? _____

Names and ages of children (including step and foster children): _____

_____

Relationship strengths and/or values: _____

Current relationship or family stressors: _____

_____

Therapy Goals and History

What brings you in? _____

What do you hope to gain or change? _____

Who supports you in your decision to begin counseling? _____

Have you seen a therapist before? Yes ____ No ____ When? _____From 1-10, rate previous experiences: _____

Name(s) of previous therapist(s): _____ Phone: (____) _____

_____

What helped? _____ What didn't? _____

Symptom Checklist

Check 0, if you are not currently bothered by the symptom; 1, if it is a mild concern; 2, if it is a moderate concern and 3, if it is a serious concern.

Symptom	0	1	2	3	Symptom	0	1	2	3
Depression					Sleep Trouble				
Grief and loss					Fatigue				
Loss of appetite					Weight gain or loss				
Apathy or lack of motivation					Suicidal thoughts or attempts				
Substance abuse					Feelings of worthlessness				
Headaches					Social isolation				
Guilt/Shame					Poor attention or focus				
Indecision					Self-esteem issues				
Mood swings					Unusual or racing thoughts				
Anger					Aggression/violence				
Anxiety or worry					Panic attacks				
Phobias					Obsessions				
Compulsive behavior					History of abuse or trauma				
Feeling detached or distant					Hearing or seeing things				
Self-harming or cutting					Relationship distress				
Domestic violence					Legal difficulties				

Symptom	0	1	2	3	Symptom	0	1	2	3
Work or school difficulties					Financial stressors				
Spiritual or religious concerns					Sexual dissatisfaction				
Poor grooming					Irritability				
Binging/purging					Anorexia				
Other: _____					Other: _____				

Psychiatric Treatment History

Have you seen a psychiatrist in the past? Yes ____ No ____ Name/phone: _____

Are you currently seeing a psychiatrist? Yes ____ No ____ Name/phone: _____

Current medications and supplements, along with dosage: _____

_____

_____

Have you been hospitalized? Yes ____ No ____ For what concern? _____When? _____

Location/Facility name: _____

Has anyone else in your family had similar psychological or emotional difficulties and/or concerns? Please explain.

_____

_____

_____

_____

Substance Use Inventory

	Age of first use	When last used	Current frequency and amount	Previous treatment	Family members with past or current use issues.
Alcohol				Yes No	
Marijuana/ Hashish				Yes No	
Meth/ "Speed"				Yes No	
Cocaine/ Crack				Yes No	
Heroin				Yes No	
Prescription drugs				Yes No	

	Age of first use	When last used	Current frequency and amount	Previous treatment	Family members with past or current use issues.
Inhalants				Yes No	
Ecstasy/ Molly				Yes No	
Mushrooms				Yes No	
Caffeine				Yes No	
Nicotine				Yes No	
Other:				Yes No	
Other:				Yes No	

Socio-Economic History

Living Situation
- Housing adequate
- Homeless
- Housing overcrowded
- Dependent on others
- Housing dangerous/ deteriorating
- Living companions unstable

Employment
- Employed and satisfied
- Employed but dissatisfied
- Unemployed
- Conflicts at work
- Unstable work history
- Disabled

Military History
- Never in the military
- Served with no incident
- Served with incident: _____

_____

Financial Situation
- No current financial stress
- Large debt
- Low income
- Impulse spending
- Relationship conflict over money

Social Support System
- Supportive network of friends and family
- Few friends
- New to the area
- No friends
- Geographically or emotionally distant from family

Sexual History

Currently active: Yes No
Currently satisfied: Yes No
Age of first sexual experience:
_____

Age of first pregnancy/fatherhood:
_____

Legal History
- No legal problems
- Parole/probation
- Arrest(s) not substance related
- Arrest(s) substance related
- Jail/Prison time

Last legal difficulty: _____

_____

Cultural and Spiritual History

Cultural identity: _____Spiritual identity: _____

Importance of spirituality/religion: Low Med High

Are you currently active in your community? _____If so, describe: _____

Do you currently engage in spiritual activities? _____If so, describe: _____