

CONTACT INFORMATION

First Name: _____

Last Name: _____

Nickname/Preferred Name: _____

Referred by: _____

Address: _____

City: _____

State: _____ Zip: _____

Email: _____

Home () _____ - _____

Work () _____ - _____

Cell () _____ - _____

Which is your preferred number to receive messages? home work cell (circle one)

Is it ok to leave a detailed message at this number? yes no (circle one)

Emergency Contact #1:

Emergency Contact #2:

Name: _____ Name: _____

Relationship to you: _____ Relationship to you: _____

Phone Number: _____ Phone Number: _____

Insurance Information:

Company Name: _____

Plan/Group Number: _____

MEDICAL CONTACT INFORMATION

Your Physician: _____

Address: _____

Phone Number(s): _____

Psychiatrist: _____

Address: _____

Phone Number(s): _____

Alternative Health Care Providers (i.e. acupuncture, chiropractic, massage, naturopathic):

1. Name: _____

Modality: _____

2. Name: _____

Modality: _____

PERSONAL HISTORY

Your birthdate/age: _____

Place you were born: _____

Places you have lived: _____

Languages you speak: _____

What is your current level of Education/completed degree(s) from which institutions?

EMPLOYMENT:

Do you work at the present time? yes no (circle one)

Full or part time? _____

Who is your current employer? _____

Self-employed? yes no (circle one)

Are you a student? yes no (circle one)

Full or part time? _____

Are you a stay at home parent? yes no (circle one)

Are you retired? yes no (circle one)

Are you partially or fully supported by savings or family? yes no (circle one)

Do you receive disability? yes no (circle one)

If yes, briefly describe.

YOU AND YOUR FAMILY:

What is your ethnic identity? _____

Do you/have you had a religious affiliation/upbringing? If yes, please describe.

Do you have a spiritual orientation/belief system? If yes, please describe.

Do you live by yourself or with others (if so, with whom)?

How do you refer to your sexual orientation/gender identity?

Are you currently in a relationship (partnership/marriage/dating relationship), separated or divorced? If yes, please describe.

If you are in a current relationship is this relationship monogamous? Please explain, if relevant.

Is there current or a history of physical or emotional abuse in this relationship or in other relationships from your past? If yes, please explain:

Do you have children? (include ages and gender). Please note if your children are biological or adopted, and whether they live with you.

Do you have any pets? If yes, please specify, and if you have you lost any pets please include.

Does your family of origin (i.e. parents/siblings/Grandparents etc.) live geographically close to you?

Please list important members, sibling birth order, and additional relatives who are/have been important to you.

Are there any issues of estrangement or enmeshment with respect to your family of origin? If yes, please briefly describe.

Have you served in the military or has anyone in your family served, deployed, fought in a war? If yes, please briefly describe.

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Have you or a previous generation been displaced due to a war or as a political refugee/seeker of asylum?
If yes, please briefly describe.

Have you or close family members experienced stress related symptoms due to war, abuse, experiences of racism, discrimination, or marginalization?

Have you or close family members been diagnosed with PTSD (Post Traumatic Stress Disorder)? If yes, please explain.

Has anyone in your family attempted/committed suicide? If so, please elaborate.

HEALTH AND WELLNESS HISTORY

Do you exercise regularly? yes no (circle one)

If yes, please briefly describe/if no, please briefly describe:

Briefly explain your eating habits: meals/snacks per day, types of food, bought prepared/cooked by you/fresh. Describe any food allergies.

Are you currently taking any medical and/or psychopharmacological medications?

If yes, please describe:

Current Prescriptions/Dosage:

Prescribing Dr./contact information if not listed on page 1:

Have you taken any medications in the past? yes no (circle one)

If yes, please describe and include medical and/or psychopharmacological medications taken in the past and include dosage:

Do you experience any side effects from your medication? If yes, please describe.

Do you take vitamins/herbs/naturopathic medicine/medicinal tea:

Do you have allergies? If yes, please describe.

Do you live with or have you lived with a medical condition, either resolved or chronic?
If yes, please describe:

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Are there any illnesses in your family history that make you concerned for your own health in the present, or for the future?
If yes, please describe.

Are you currently, or have you ever been depressed or anxious?
If yes, please describe:

Have you been hospitalized recently or in the past for medical or psychiatric reasons?
If yes, please describe:

Have you ever had suicidal thoughts? If so, at what point/s in your life? (Please note if you are currently experiencing chronic or passing suicidal thoughts.)

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Have you ever attempted suicide? If so, please describe the circumstances and your follow-up care. Please also note if you currently think about/experience the urge to carry out this plan or another version.

Have you had previous experience in therapy (months/years)? Please explain reasons for endings:

What recreational substances do you use, or have you used in past including alcohol, cigarettes, prescription, or over-the-counter medications?

How often do you use these substances (if not currently using, how often in past)?

Is your substance use of concern to you or those who care about you?
If yes, please describe.

Have you been treated for Alcohol Use/Dependence/Abuse?

yes no (circle one)

Substance(s): _____

Have you been treated for Drug Use/Dependence/Abuse?

yes no (circle one)

Substance(s): _____

Dates of treatment:

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Treatment Program/Facility/AA meeting:

Are you experiencing any sleep difficulties including: insomnia, hypersomnia, narcolepsy, dream disturbances or have you in the past?

If yes, please explain:

Are you having any difficult with your appetite or eating habits/have you in the past?

If yes, please explain:

Have you ever been formally diagnosed with or recognize that you have an eating disorder (i.e. anorexia, bulimia, mixed anorexia/bulimia, exercise bulimia, compulsive overeating (with or without purging)?

If yes, please explain:

Do you currently or have you experienced compulsive urges or behaviors which may include: frequent hand washing, checking and re-checking, repetitive behaviors, obsessive thinking with respect to worries, obsessive thinking with respect to sexual urges, obsessive thinking with respect to death and dying?

If yes, please explain:

