This form will be used by your therapist. Please answer as many questions as possible.

Name:____ **Date:**__________________________

Please describe primary reasons for seeking mental health treatment:

____

____

When did you first notice the problem/symptoms?

____

How have you been coping with this until now?

____

What do you hope the outcome of therapy will be?

____

Briefly describe any history of trauma:

____

____

Please describe any family history of mental illness or addiction.

____

Are you currently having suicidal thoughts? ☐ Yes ☐ No

Are you currently engaging in self-harming behavior? ☐ Yes ☐ No

Do you have a history of self-harming or suicidal behavior? ☐ Yes ☐ No

Do you currently see a psychiatrist? ☐ Yes ☐ No

If yes: Name:______________________________ Date of last evaluation ____________________

Substance Use History

Past	Current	Substance	Frequency	Amount	Age Start Using?	Age Stop Using?
☐	☐	Alcohol, including social/casual use				
☐	☐	Cannabis				
☐	☐	Tranquilizers (Benzos, Xanax, Klonopin)				
☐	☐	Opiates (Heroin, Codeine)				
☐	☐	Stimulants (Cocaine, Meth, Diet Pills)				
☐	☐	Hallucinogens (PCP, LSD, Ecstasy)				
☐	☐	Other Depressants & Sedatives				
☐	☐	Overuse/abuse of prescription medications.				
☐	☐	Other:				

Education History

Highest Grade Completed: _____________________ Specialized Training: _______________

Educational Strengths: ____

Educational Problems: ____

Medical Information

Name of Primary Care Physician __________________________Date of last physical exam ________________________

Please check all current and past medical problems:

	Allergies/Asthma		Disorderly Eating		Problems with Sleep
	Arthritis		Hearing		Sexually Transmitted Disease
	Cancer		Heart Disease		Thyroid Problems
	Chronic Pain		High Blood Pressure		Vision Problems
	COPD		Migraines, Severe Headaches		Weight Problems
	Diabetes		Other:		

Please list all current medications: (Name and dosage)

Medication ____Dosage____________________________

Medication ____Dosage____________________________

Medication ____Dosage____________________________

Medication ____Dosage____________________________

Do you have any allergies? If yes, please describe the allergen and reaction.

Allergy ____Reaction____

Allergy ____Reaction____

Family History

Please list the names of your birth parents and other parental figures that have had a significant impact on you and/or the family. You may also list other family members if they have had a significant impact on you and/or your family. Rate the quality of the relationship with each individual on a scale of 0-10 (0-very bad, 10 – very good)

Mother ______________________________ Still living? Y or N Quality of Relationship________

Father _______________________________ Still living? Y or N Quality of Relationship________

Name _______________________________ Still living? Y or N Quality of Relationship________

Name _______________________________ Still living? Y or N Quality of Relationship________

Please list all the people with whom you currently live. Include name, age, and quality of relationship on scale of 0-10

Name ____________________________________Age__________ Quality of Relationship_____________

Name ____________________________________Age__________ Quality of Relationship_____________

Name ____________________________________Age__________ Quality of Relationship_____________

Name ____________________________________Age__________ Quality of Relationship_____________

Individual Strengths and Natural Supports

Spiritual Beliefs: ____

Culture:____

Please list at least two interests, activities, or hobbies that you enjoy:

____

What are your personal strengths (beliefs, attitudes, abilities, skills, experiences, personality, etc.)?

____

Briefly describe yourself when you are functioning at your best:

____

Please check any community supports that you are currently using:

☐ AA/NA ☐ Housing ☐ LINK ☐ Medicare/Medicaid ☐ SSI/SSDI ☐ Other:___________

Employment History

Are you currently employed? ☐ Yes ☐ No

Please describe previous work experience. Include current employment if applicable:

____

____

Have mental health issues or substance abuse impacted your ability to work effectively? If yes, please describe:

____

What personal strengths and vocational skills do you already have that are helpful or could be helpful in a job?

____

Legal History

Have you ever been arrested or convicted of a crime? If yes, please list all offenses including dates:

____

____

____

Please check all symptoms you have had in the past 30 days.

	Symptom Cluster A				
	Appetite or Weight Increase/Decrease		Feelings of Hopelessness		Neglect of Critical Role Functions
	Decreased Concentration		Feelings of Worthlessness		Psychomotor Retardation
	Depressed Mood		Inappropriate Guilt		Recurrent Suicidal Behaviors
	Diminished Interest/Pleasure in Activities		Insomnia/Hypersomnia		Social Withdrawal, Isolation
	Fatigue, Lack of Energy		Irritability		Tearfulness, Crying
	Symptom Cluster B				

	Anxious Mood		Fears/Phobias		Panic/Shortness of Breath/Sweat/ Palpitations
	Engages in Repetitive Acts/Rituals		Hypersensitivity		
	Distractibility/Poor Concentration		Hypervigilance		Restlessness
	Exaggerated Startle Response		Intrusive/Repetitive Thoughts/Images		Restricted Food/Binge/Purge
	Excessive Worry		School/Work Refusal		
Symptom Cluster C					
	Blackouts from Using a Substance		Failure to Fulfill Social Roles		Tolerance/Increased Use
	Craving a Substance		Legal Problems (DUIS, etc.)		Unable to Abstain from Substances
	Delirium Tremens		Seizures		Withdrawal
Symptom Cluster D					
	Attention Drawn to Irrelevant Stimuli		Inflated Self Esteem		Paranoia
	Decreased Need for Sleep		Labile/Unstable Mood		Psychomotor Agitation
	Impulsivity Leading to Neg. Consequence		More Talkative than Usual		Racing Thoughts
Symptom Cluster E					
	Anger Outbursts		Dramatic/Restricted Emotions		Property Destruction
	Argues/Defies Rules/Authority		Mistrust/Suspicion of Others		Self Harm
	Blames Others for Mistakes		Persistent Feelings of Emptiness		Shoplifting/Theft/Criminal Acts
	Cruelty to Animals		Physical Destruction/Assaults		Touchy/Easily Annoyed/Irritated
	Detachment from Social Relationships				
Symptom Cluster F					
	Auditory/Visual Hallucinations		Irrationality/Delusions		Neglect of Role Functioning
	Confusion/Disorg. Thinking/Speech		Lack of Motivation		Neglected Self Care
	Flattened Affect		Has difficulty waiting turn		
Symptom Cluster G					
	Difficulty Organizing Tasks/Details		Hyperactive/Unable to Sit Still		Lacks/Delay/Impaired language/ communication/verbal skills
	Difficulty Processing Sensory Input		Impulsive, Unable to wait turn, Blurts Things Out		Repetitive Motor Mannerisms, Over focused Areas of Interest
	Difficulty Sustaining Attention in Tasks/Details		Lacks ability to develop Age Appropriate Peer Relationships		Rigidity to Rules/Unable to handle changes
	Easily Distracted by Outside Stimuli/Forgetful		Lacks Social/Emotional Reciprocity in Relationships		Other: