FOR ADULT AND ADOLESCENT CLIENTS

I am seeking: □ Individual □ Couple □ Group Therapy

CLIENT INFO	STATUS
Date of Birth: ____/_____/_____ Age: _____ Name: Preferred Name: Preferred Gender Pronouns: Gender: M □ F □ Other: Address: City: Zip: Email: Home #: Cell #: Work #: Other #: On what number may we leave a confidential message: □Home ❑Cell □Other	□ Employed Employer: _____ Address: _____ City: _____Zip: _____ □ Self-employed □ Unemployed □ Retired □ Student □ Disabled I am : ❑ Single ❑ Married □ Separated ❑ Divorced □ Widowed How many people live in your household? ____

EMERGENCY CONTACT INFO	HEALTH AND MEDICAL
Emergency Contact: Phone: Relationship to client:	Primary Care Physician (Name and Phone #): Psychiatrist (Name and Phone #): Please list any medical problems: Please list all current medications:

SYMPTOM ASSESSMENT

I AM EXPERIENCING…	**Never**	**Seldom**	**Often**	**Always**	**For how long?**
Frequent worry or tension					
Fear of many things					
Discomfort in social situations					
Phobias (unusual fears about specific things)					
Panic Attacks: Sweating, trembling, shortness of breath, heart palpitations					
Recurring, distressing thoughts about a trauma					
"Flashbacks" as if reliving the traumatic event					
Avoiding people/places associated with the trauma					
Nightmares about traumatic experiences					
I AM FEELING…					
Decreased interest in pleasurable activities					
Social isolation, loneliness					
Suicidal thoughts					
Bereavement or Feelings of Loss					
Changes in sleep (too much or not enough)					
Normal, daily tasks require more effort					
Sad, hopeless about the future					
Excessive feelings of guilt					
Low self-esteem					
I NOTICE…					
I am angry, irritable, hostile					
I feel euphoric, energized and highly optimistic					
I have racing thoughts					
I need less sleep than usual					
I am more talkative					
My moods fluctuate: go up and down					
I HAVE…					
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tell me					
Intrusive or strange thoughts					
Obsessive thoughts					
Been hearing voices when alone					
Problems with my speech					
Risk taking behaviors					
Compulsive or repetitive behaviors					
Been acting without concern for consequence					
Been physically harming myself					
Been violent toward other(s)					
I USE THE FOLLOWING	**Never**	**Seldom**	**Often**	**Always**	**For how long?**
Alcohol					
Nicotine					
Marijuana					
Cocaine					
Opiates					
Sedatives					

Hallucinogens					
Stimulants					
Methamphetamines					
MY EATING INVOLVES…					
Restriction of food					
Binge Eating followed by vomiting, spitting up, use of diuretics, or excessive exercise					
Binge Eating					
A lot of weight loss or gain for any other reason					
I HAVE…					
Concern about my sexual function					
Discomfort engaging in sexual activity					
Questions about my sexual orientation					
Questions about my gender identity					
EMPLOYMENT AND SELF CARE					
I have problems getting/keeping a job					
I have problems paying for basic expenses					
I am afraid of becoming homeless					
I have problems accessing healthcare					

PERSONAL AND FAMILY HISTORY

Have you or a close relative ever been hospitalized for a psychiatric illness? □Yes □No
Does anyone in your family have a mental illness? □Yes □No
Has anyone in your family ever attempted or committed suicide? □Yes □No
Have you ever attempted suicide? □Yes □No
Does anyone in your family have a substance abuse problem? □Yes □No
Have you ever been arrested? □Yes □No

If "yes" to any of the above, please briefly explain: _____
_____
_____
_____