Asheville Psychotherapy Services, PLLC

Change Is Possible.

Date: _____ Name: _____

Permanent Address: _____
Street Address, City, State

Phone Number: _____ Email Address: _____

Can I communicate with you and leave you messages via Phone, Text, and Email? _____

Emergency Contact Name and Number: _____

Birth Date/Age: _____ Gender Identity/ Pronouns: _____

Racial or Ethnic Identity: _____ Military Experience: _____

Who makes up your immediate family? People/Pets: _____

_____

Are you currently employed? Y N

If yes, where: _____ Title/Role: _____

How did you hear about me? _____

Concern Checklist:

*Step 1: Put an "X" before all areas that are of concern to you. Skip those that are not.
*Step 2: After each area of concern, circle the degree to which the concern is currently problematic.

	Mild	Moderate	Serious	Severe
___ 1. Relationship Difficulties: breakup/loss of relationship; problems with romantic partner, friends or family	1	2	3	4
___ 2. Depression/Moods: depressed mood, loss of interest or pleasure, hopelessness; alternating periods of elevated and depressed mood	1	2	3	4
___ 3. Suicidal thoughts or concerns: problems related to thoughts of suicide	1	2	3	4
___ 4. Anxiety/Emotional Regulation: excessive or uncontrolled worry, nervousness, chronic fears, performance anxiety, panic attacks, social anxiety, obsessive thoughts	1	2	3	4
___ 5. Stress or Psychosomatic Symptoms: overwhelmed by circumstances, problems with headaches, stomach pains, etc.	1	2	3	4
___ 6. Self-Esteem/Body Image: concerns about self-image, shyness, insecurity	1	2	3	4

___ 7. Death or Loss: grief related to loss of a valued other	1	2	3	4
___ 8. Existential/Spiritual Concerns: search for meaning in life, concern about the role of religion in one's life	1	2	3	4
___ 9. Alcohol and/or Substance Use: concerns about abuse or developing dependency on alcohol or other drugs	1	2	3	4
___ 10. Past Trauma _____	1	2	3	4
___ 11. Other: _____	1	2	3	4

Physical/Mental Health/Wellness History:

Please indicate if you personally have been the target of any of the following at any point in your life.
Put an "X" next to all that apply.

Physical Abuse _____ Sexual Abuse _____
Emotional or Verbal Abuse _____ Neglect _____

How would you describe your overall physical health? _____

Have you ever had any chronic health conditions, major illnesses, or significant head trauma? _____

If yes, please describe: _____

Do you have a diagnosed pre-existing mental health condition? _____

If yes, please specify: _____

Do you have any previous experience with counseling? _____

If yes, what did you find helpful or unhelpful about your previous experience(s)? _____

_____

_____

Do you regularly take any medications (including over-the-counter) for mental health concerns? _____

If yes, is your medication being monitored by a physician or other health care professional? _____

Have you ever had significant concerns about your eating habits? _____

Have you ever thought that you had a problem with alcohol or other drug use? _____

If yes, have you ever sought treatment? _____

Do you participate in movement/exercise regularly? _____

Do you practice specific forms of self-care? _____

If yes, describe your practice: _____

_____

How satisfied are you with the quality and quantity of your sleep? _____

Do you consider yourself to be spiritual or religious? _____

If so, describe your faith or belief: _____

_____

Goals:

What do you hope to achieve through therapy at this point in time? _____

_____

_____

How will you know if you have reached your goal(s)? _____

_____

_____

What are the main sources of support in your life? _____

_____

_____

What would you consider to be your greatest strengths? _____

_____

_____

Thank you for taking time to share and I look forward to learning more about you!

_____ _____

Signature Date