



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, Email? _____

Emergency Contact Name and Number: _____

Birth date/Age: _____ Gender Identification/Pronouns _____

Racial/Ethnic heritage? _____ Military Experience: _____

Who makes up your immediate family? People/Pets _____

Are you currently employed? Y N If yes, where: _____ Title: _____

Who can I thank for referring you? _____

Concern Checklist:

*Step 1: Check only those items that are of concern to you. Skip those that are not.

*Step 2: For each checked item, 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
___ 7. Self-esteem/body image: concerns about self-image, shyness, insecurity	1	2	3	4
___ 8. Death or loss: grief related to loss of a valued other	1	2	3	4

___ 9. Existential/spiritual concerns: search for meaning in life, concern about the role of religion in one's life	1	2	3	4
___ 10. Alcohol and/or chemical use: concerns about abuse or developing dependency on alcohol or other drugs	1	2	3	4
___ 12. Past Trauma _____	1	2	3	4
___ 13. Other: _____	1	2	3	4

Physical/Mental Health/Wellness History:

Please indicate if you personally have been the target of any the following: (Check all that apply)

- | | |
|----------------------------------|---------------------|
| ___ 1. Physical abuse | ___ 3. Sexual abuse |
| ___ 2. Emotional or verbal abuse | ___ 4. Neglect |

How would you describe your overall physical health? (circle one) Excellent Good Fair Poor

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

If Yes, please describe: _____

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

If Yes, please specify: _____

Do you have any previous experience with counseling? Y N

What did you find helpful or unhelpful about your previous experience(s)? _____

Do you regularly take any medications (including over-the-counter) for psychological difficulties? Y N

If yes, Is your medication being monitored by an M.D. or other health care professional? Y N

Have you ever had significant concerns about your eating habits? Y N

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

If yes, have you ever sought treatment? Y N

Do you exercise regularly? Y N

Do you practice other forms of self-care? Y N

If yes, describe your practice: _____

Are you satisfied with the quality and quantity of your sleep? Y N

Do you consider yourself to be spiritual or religious? Y N

If yes, please 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 complete this questionnaire. This information will assist us in assessing your current needs
Please note that this information will be kept strictly confidential even after therapy is complete.**