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| Personal Information | | |
| First Name: Click here to enter text. | Last Name: Click here to enter text. | |
| Date of Birth: Click here to enter text. | Race/Ethnicity: Click here to enter text. | |
| Preferred Gender: Click here to enter text. | Sexual Orientation: Click here to enter text. | |
| Phone Number: Click here to enter text. | Email Address: Click here to enter text. | |
| Address:  Click here to enter text. | | |
| Emergency Contact: Click here to enter text. | | Relation: Click here to enter text. |
| Phone Number: Click here to enter text. | | |
| Address:  Click here to enter text. | | |
| Can they get to you if necessary? YES  NO | | |
| If No, list the reason why:  Click here to enter text. | | |
| History | | |
| 1. What brings you in today?   Click here to enter text. | | |
| 1. Were you referred to us? YES  NO | | |
| \*If yes, who referred you?  Click here to enter text. | | |
| 1. Have you been to therapy? YES  NO | | |
| \*If yes, please indicate the approximate date(s) and reason(s) for therapy:  Click here to enter text. | | |
| 1. Have you ever been diagnosed with a mental disorder? YES  NO | | |

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| \*If yes, what were the diagnoses?  Click here to enter text. |
| 1. Do you have a family history of mental illness? YES  NO |
| \*If yes, please describe (i.e., who in your family, what diagnoses, etc)  Click here to enter text. |
| 1. Have you ever been hospitalized or been in treatment for psychiatric, alcohol or drug reasons?   YES  NO |
| \*If yes, please indicate purpose, location of treatment and approximate treatment dates:  Click here to enter text. |
| 1. Are you currently using any illicit substances? YES  NO |
| \*if yes, please indicate what you are currently using and at what frequency:  Click here to enter text. |
| 1. Do you drink alcohol? YES  NO |
| \*If yes, please indicate how often and how much:  Click here to enter text. |
| 1. Are you currently taking any over-the-counter or prescribed medication? YES  NO |
| \*If yes, please list any medications you are currently taking:  Click here to enter text. |
| 1. Do you have a family history of substance abuse? YES  NO |
| \*If yes, please describe:  Click here to enter text. |
| 1. Have you ever had thoughts about ending your life? YES  NO |
| \*if yes, please describe how often and most recent date:  Click here to enter text. |
| 1. Have you ever engaged in self-injurious behavior (i.e., cutting, burning, picking, etc)?   YES  NO |
| \*If yes, please indicate approximate dates and method of self-injury:  Click here to enter text. |
| 1. Have you ever attempted to end your life? YES  NO |
| \*If yes, please indicate number of times and approximate dates:  Click here to enter text. |
| 1. Are you currently having thoughts of harming yourself? YES  NO |
| 1. Have you ever had thoughts of harming others? YES  NO |
| \*if yes, please describe:  Click here to enter text. |
| 1. Have you ever experienced any major injury? YES  NO |
| \*If yes, please describe:  Click here to enter text. |
| 1. Have you ever experienced a trauma? YES  NO |
| \*If yes, please describe:  Click here to enter text. |
| 1. My daily mood is:   Depressed  Hopeless  Frightened  Anxious  Elevated  Irritable  Numb  Happy  Tired  Sad  Other |
| \*If you selected other, please specify:  Click here to enter text. |
| 1. Please list any significant medical history (i.e., surgeries, head injuries, pregnancies, chronic illnesses, seizures, etc.):   Click here to enter text. |
| 1. Please provide any other mental health professionals you are currently seeing. This includes: Counselor/Therapist, Social Worker, Case Manager, Psychologist, Psychiatrist or any other provider.   Click here to enter text. |
| 1. Is there any other information you think is important for your therapist to know?   Click here to enter text. |

Click here to enter text. Click here to enter a date.

Client Signature Date

Click here to enter text. Click here to enter a date.

Parent Signature Date

*Sign if client is under the age of 18*