INFORMATION SHEET

Please complete this form and bring it to your first meeting

Contact Information:

Name: _____Date: _____

Phones: Cell_____ Hm_____ Wk_____

Address (with zip):_____

_____

Email:_____

Emergency Contact:_____ Phone #:_____

Relationship:_____

Background:

Age:_____ DOB:_____ Gender:_____ Religion (if any):_____
Partner Status:_____ Sexual Orientation:_____ Gender ID:_____
Ethnicity:_____ National Origin:_____ Ableism:_____

Education and Work:

Highest Degree:_____ Occupation:_____ Employer:_____

Insurance:

Insurance Company:_____ Policy #:_____

Employee Assistance Program:_____ Victim Assistance:_____

Family Information:

Spouse or Domestic Partner:_____ age:____ gender:____

Have you ever been divorced or permanently separated from a spouse or domestic partner? Yes___ No___ If yes, how many times?____

Children:

relationship: _____ age:____
relationship: _____ age:____
relationship: _____ age:____
relationship: _____ age:____
relationship: _____ age:____
relationship: _____ age:____

Parental Figures (Parents, Co-parents, Step-Parents, Foster Parents, Grandparents):

relationship: _____ age:____ occupation: _____
relationship: _____ age:____ occupation: _____
relationship: _____ age:____ occupation: _____
relationship: _____ age:____ occupation: _____

Who primarily raised you? _____

Siblings:

relationship: _____ age:____
relationship: _____ age:____
relationship: _____ age:____
relationship: _____ age:____
relationship: _____ age:____
relationship: _____ age:____

Medical:

Do you have any serious or chronic medical conditions? Yes____ No___
If yes, please describe_____

Have you had any head injuries? Y___ N___
If yes, please explain: _____

Are you currently under medical care? Y___ N___ If yes, please list your medical providers.

Doctor/LNP/LPA:_____	Phone:_____	Primary:_____
Doctor:_____	Phone:_____	Specialty:_____
Doctor:_____	Phone:_____	Specialty:_____
Doctor:_____	Phone:_____	Specialty:_____

Please list any medications you are currently taking.

Medicine:_____	Dose:_____	Purpose:_____
Medicine:_____	Dose:_____	Purpose:_____
Medicine:_____	Dose:_____	Purpose:_____
Medicine:_____	Dose:_____	Purpose:_____

Do you utilize any alternative treatments such as acupuncture, homeopathy, naturalpathy, colonics, body work, chiropractic? Y___ N___
If yes, what have you used?_____
Was it helpful? Y___ N___

Do you have any attention or learning concerns? Y___ N___
If yes, please explain:_____

Mental Health:

Have you ever worked with a psychologist or psychotherapist? Yes ____ No____

If yes: When approx.?_____For how long?_____

Name of prior therapists _____

What did you focus on? _____

_____

Was it helpful? Yes___ No___ Please explain:_____

_____

Are you currently working with a psychiatrist? Yes___ No___

Name:_____ Phone #:_____

Have you ever worked with a psychiatrist for medication? Yes ____ No____

If yes: When approx.?_____For how long? _____

Name of psychiatrist?_____

What did you focus on? _____

_____

Was it helpful? Yes___ No___ Please explain:_____

_____

Have you ever been hospitalized for psychological reasons? Yes___ No___

If yes: When? _____ How many times? _____

Where? _____ For what reason?_____

_____

Was it helpful?_____

Are you currently having thoughts of harming yourself? Yes___ No___

Have you made any suicide attempts in the past? Yes___ No___

If yes, please explain:

_____

_____

Has anyone in your family participated in therapy? Yes___ No___

If yes, please explain:

_____

_____

Briefly describe what brings you to therapy:

How much distress are you currently experiencing?

1	2	3	4	5	6	7	8	9	10
minimal									severe

How do you hope therapy will help you?