

Name: _____

Telephone number where you can be reached: _____ OK to leave a detailed message? Yes No

General Information

Current Living Arrangements

I live in a: House Apartment Other _____

With whom do you live? _____

Race/Ethnic Ancestry:

Caucasian/White American Indian/Alaskan Other: _____

Black Asian

Hispanic Pacific Islander

Current Problems

How would you rate your level of DEPRESSION on a scale of 1 to 10 with 10 being the most severe? _____

How would you rate your level of ANXIETY on a scale of 1 to 10 with 10 being the most severe? _____

What is the primary issue that brings you to therapy today? _____

Mental Health History

Have you been diagnosed with an emotional/psychiatric difficulty? Yes No

Diagnosis/Problem _____

Having you ever received counseling or therapy for an emotional difficulty? Yes No

When/Where? _____

Have you ever been hospitalized for an emotional difficulty? Yes No

When/Where? _____

Have you ever taken medications for an emotional difficulty? Yes No

Which ones? _____

Anyone in your family have mental illness or an emotional difficulty? Yes No

Specify _____

Do you have access to weapons (e.g. guns, knives)? Yes No

Do you have CURRENT thoughts of suicide or self-harm? Yes No

Do you have a prior history of suicide attempts? Yes No

Specify _____

Do you have CURRENT thoughts about homicide or hurting someone? Yes No

Trauma History

Check any of the following that you experienced and when it occurred:

	Before Age 18	After Age 18
Physical abuse/assault	[]	[]
Sexual abuse/assault/molestation	[]	[]
Emotional abuse	[]	[]
Neglect	[]	[]
Death of a family member	[]	[]
Death of a close friend	[]	[]
Witnessed domestic abuse	[]	[]
Natural disaster	[]	[]
Neighborhood violence	[]	[]
Serious motor vehicle accident	[]	[]

Please explain: _____

Medical History

Current medical problems: _____

Legal History

Have you ever been in jail/prison? [] Never [] Less than 2 weeks [] More than 2 weeks

Are you on probation, parole, or are you awaiting a pending court case? [] Yes [] No

Substance Use History

On the average, how many days per week do you use alcohol? _____ (Put N/A if you do not drink)

On the average, how many drinks do you have per sitting? _____

On the average, how many days per week do you use illicit drugs? _____ (Put N/A if you do not use drugs)

What type(s) of drugs do you use? _____

On the average, how much do you use on each occasion? _____

Are you concerned about your current drinking or drug usage? [] Yes [] No

Do you smoke cigarettes? [] Yes [] No How much do you smoke each day? _____

Do you use other tobacco products? [] Yes [] No

Describe type and how often _____

