

Cell/Other Phone: (_____) _____ May we leave a message? Yes No

E-mail: _____ May we email you? Yes No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

No

Yes, previous therapist/practitioner: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in: _____

4. Please list any difficulties you experience with your appetite or eating patterns.

5. Are you currently experiencing overwhelming sadness, grief or depression?

No

Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?

No

Yes

If yes, when did you begin experiencing this?



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7. Are you currently experiencing any chronic pain?

- No
- Yes

If yes, please describe? _____

8. Do you drink alcohol more than once a week?

- No
- Yes

9. Are you currently in a romantic relationship?

- No
- Yes

If yes, for how long? _____

10. Are you currently employed? If so, who is your employer? _____

11. What significant life changes or stressful events have you experienced recently:

12. What are your goals for therapy?
