This form will be used by your therapist. Please answer as many questions as you are able.

Name:____ **Date:**____________________

Please describe primary reasons for seeking mental health treatment:

____

____

When did you first notice the problem/symptoms?

____

How have you been coping with this until now?

____

What do you hope the outcome of therapy will be?

____

Briefly describe any history of trauma:

____

____

Please describe any family history of mental illness or addiction.

____

____

Are you currently having suicidal thoughts? ☐ Yes ☐ No

Are you currently engaging in self-harming behavior? ☐ Yes ☐ No

Do you have a history of self-harming or suicidal behavior? ☐ Yes ☐ No

Do you currently see a psychiatrist? ☐ Yes ☐ No

If yes: Name:__________________________________ Date of last evaluation ______________________

Substance Use History

Past	Current	Substance	Frequency	Amount	Age Start Using?	Age Stop Using?
☐	☐	Alcohol, including social/casual use				
☐	☐	Cannabis				
☐	☐	Tranquilizers (Benzos, Xanax, Klonopin)				
☐	☐	Opiates (Heroin, Codeine)				
☐	☐	Stimulants (Cocaine, Meth, Diet Pills)				
☐	☐	Hallucinogens (PCP, LSD, Ecstasy)				
☐	☐	Other Depressants & Sedatives				
☐	☐	Overuse/abuse of prescription medications.				
☐	☐	Other:				

Medical Information

Name of Primary Care Physician ___________________________Date of last physical exam ___________________

Please check all current and past medical problems:

	Allergies/Asthma		Disorderly Eating		Problems with Sleep
	Arthritis		Hearing		Sexually Transmitted Disease
	Cancer		Heart Disease		Thyroid Problems
	Chronic Pain		High Blood Pressure		Vision Problems
	COPD		Migraines, Severe Headaches		Weight Problems
	Diabetes		Other:		

Please list all current medications: (Name and dosage)

Medication ____Dosage____________________________

Medication ____Dosage____________________________

Medication ____Dosage____________________________

Medication ____Dosage____________________________

Do you have any allergies? If yes, please describe the allergen and reaction.

Allergy ___________________________________Reaction____

Allergy ___________________________________Reaction____

Family History

Please list the names of your birth parents and other parental figures that have had a significant impact on you and/or the family. You may also list other family members if they have had a significant impact. Rate the quality of the relationship with each individual on a scale of 0-10 (0-very bad, 10 – very good)

Mother ______________________________ Still living? Y or N Quality of Relationship________

Father _______________________________ Still living? Y or N Quality of Relationship________

Name _______________________________ Still living? Y or N Quality of Relationship________

Name _______________________________ Still living? Y or N Quality of Relationship________

Please list all the people with whom you currently live. Include name, age, and quality of relationship on scale of 0-10

Name ____________________________________Age__________ Quality of Relationship_____________

Name ____________________________________Age__________ Quality of Relationship_____________

Name ____________________________________Age__________ Quality of Relationship_____________

Name ____________________________________Age__________ Quality of Relationship_____________

Individual Strengths and Natural Supports

Spiritual Beliefs: ______________________________

Culture: ______________________________

Please list at least two interests, activities, or hobbies that you enjoy:

____

____

What are your personal strengths (beliefs, attitudes, abilities, skills, experiences, personality, etc.)?

____

Briefly describe yourself when you are functioning at your best:

____

Please check any community supports that you are currently using:

☐ AA/NA ☐ Housing ☐ LINK ☐ Medicare/Medicaid ☐ SSI/SSDI ☐ Other:___________

Education History

Highest Grade Completed: ______________________

Educational Strengths: ______________________________

Educational Problems: ______________________________

Specialized Training: ______________________________

Employment History

Are you currently employed? ☐ Yes ☐ No

Please describe previous work experience. Include current employment if applicable:

____

____

Have mental health issues or substance abuse impacted your ability to work effectively? If yes, please describe:

____

What personal strengths and vocational skills do you already have that are helpful or could be helpful in a job?

____

Legal History

Have you ever been arrested or convicted of a crime? If yes, please list all offenses including dates:

____

____

____

Prenatal/Developmental History

Were there any complications during pregnancy (mother was ill, used substances, etc.), during birth (long, forceps used, premature, etc.) or any developmental delays (language, motor, social, etc.).

____

____

____

____

Please check all symptoms you have had in the past 30 days.

	No symptoms observed		Destroys property		Intrudes/interrupts frequently
	Abuses laxatives		Harms/kills animals		Has difficulty making friends
	Eats too much		Hits/kicks/pushes others		Strong interest in specific things
	Eats unusual or non-food items		Lies		Repeats certain movements
	Makes self vomit		Often loses temper		Drinks alcohol
	Other eating problems		Plays with matches/fire		Smokes/uses tobacco
	Refuses to eat		Pre-occupied with violence/weapons		Uses substances
	Acts scared frequently		Refuses to do as told		Hears things others do not hear
	Is nervous/anxious		Seems to deliberately annoy others		Says things that make no sense
	Nightmares		Sets things on fire		Sees things others do not see
	Won't sleep in own bed		Steals		Stays awake for days at a time
	Worries about parents/caretakers		Threats to harm others		Makes sexual comments
	Has attempted suicide		Threats to kill others		Masturbates in front of others
	Hurts/cuts/burns self		Yells/cusses/calls names		Sexually active (consensual)
	Sad/cries frequently		Cannot complete a task		Sexually touches others (non-consensual)
	Seems to have little to no confidence		Cannot sit/stay still		
	Threats to die by suicide		Complains of boredom		Has bowel movements not in the toilet
	Threats to harm self		Easily distracted		Wets the bed or self
	Trouble falling/staying asleep		Has difficulty waiting turn		Other:

In your own words, please describe the symptoms that are impacting your life the most significantly at this time:

____

____

____

Names of persons completing this form: ____