Please complete this form to the best of your ability. Information provided here is protected as **confidential** information. Please bring to your first session.

Name:       Gender: male female  other:

DOB:       Age:      Marital Status: never married  married  divorced

widowed separated living as married other

Address:

Home number:       May I leave a message?: yes  no

Cell phone:       May I leave a message?: yes  no

Email: ­­­­­­\_\_     \_\_\_\_\_\_\_\_ (email is not a confidential form of communication, please acknowledge if consent to using it  yes no). There is confidential email through Therapy Appointments Client Portal- my electronic health record system, please request user name and password. I also use VIRTRU to encrypt emails using regular email. This allows email to be confidential. Please see electronic communications policy for additional information.

Referred by:

**Emergency Contact Information: (must be completed)**

Name:       Relationship:

Address:

Phone Number:

In the case of medical emergency, I give permission to Debra Eng to seek emergency medical care: \_\_\_\_\_\_\_ initial

**Physical Health History**

Describe your current physical health: very good good fair poor

Are you allergic to anything? (medicines, food, environmental) yes  no Describe:

Describe current/past health issues:

Describe your exercise routine:

Describe your sleep pattern:

Describe your nutrition/eating:

Describe use of complementary or alternative medicine (massage/acupuncture…):

Eating issues: Loss of control over eating binging/purging behavior rules about eating emotional eating

Describe any pain issues that you have:

Have you had any serious illness, surgeries or hospitalizations (medical)? yes  no Describe:

Are you currently taking medication for medical reasons? yes  no

|  |  |  |
| --- | --- | --- |
| Name | Dose | Purpose |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Are you currently taking any vitamins, supplements, herbals? yes  no

|  |  |  |
| --- | --- | --- |
| Name | Dose | Purpose |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Do you have a PCP? yes  no Name and Address:

Do you consent to coordinating care with your medical professionals, if requested? yes  no

**Mental Health History**

Describe your current mental health: very good good fair poor

Please check if you have experienced the following symptoms for more than 2 weeks in the last 4 weeks.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| DEPRESSION | Not at all | 1-2 days | More than ½ | Nearly all days |
| Depressed mood |  |  |  |  |
| Little interest in doing things |  |  |  |  |
| Trouble falling, staying asleep, over sleeping |  |  |  |  |
| Feeling tired, low energy |  |  |  |  |
| Poor appetite/overeating |  |  |  |  |
| Feeling badly about self |  |  |  |  |
| Difficulty concentrating |  |  |  |  |
| Thoughts of dying, wanting to die, self harming |  |  |  |  |
| History of suicide attempts or self-harm | Yes | No |  |  |
| MANIA | Not at all | 1-2 days | More than ½ | Nearly all days |
| Elevated mood |  |  |  |  |
| Decreased need for sleep |  |  |  |  |
| Racing thoughts |  |  |  |  |
| Irritability |  |  |  |  |
| ANXIETY | Not at all | 1-2 days | More than ½ | Nearly all days |
| Anxiety, excessive worrying |  |  |  |  |
| Obsessive thoughts or behaviors |  |  |  |  |
| Phobias |  |  |  |  |
| Trauma- nightmares, flashbacks, hyper-vigilance, avoidance of trauma |  |  |  |  |
| Panic attacks (sweating, heart racing, feeling choked, hot flashes, dizziness…) |  |  |  |  |
| OTHER SYMPTOMS | YES | NO |  |  |
| Paranoid thoughts |  |  |  |  |
| Hearing or seeing things that others don’t hear or see |  |  |  |  |
| History of violence |  |  |  |  |
| Homicidal Thoughts or plans |  |  |  |  |
| Distorted body image |  |  |  |  |
| ADD/ADHD |  |  |  |  |
| History of trauma |  |  |  |  |

Have you ever been hospitalized for psychiatric reasons? yes no Describe:

Please complete this table for psychiatric or substance abuse providers- Please attach additional sheet, if necessary:

|  |  |  |  |
| --- | --- | --- | --- |
| Doctor/Therapist | Location | Dates | Reason |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

\*\*\*\*Debra Eng will request a release of information to allow the coordination of care with current providers.

How often do you use alcohol: daily 3-5x/week 1-2x/week monthly less than 1x/mo none in recovery

Describe:

How often do you use non-prescribed (illegal) drugs: daily 3-5x/week 1-2x/week  monthly

less than 1x/mo none  in recovery Describe:

How much caffeine do you have daily:

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**Personal History/Demographics**

Describe significant life changes or stressful events that you have had recently:

Are you currently in a significant relationship?  yes no Describe:

Describe your education?

Describe your work situation?

Family Income:  less than $25K  $25-50,000 $50-75,000 more than $75,000

Describe your race and/or ethnicity:

Describe your faith or spiritual beliefs:

Have you experienced any of the following: divorce  significant loss  losing a job debt/financial problems legal issues  trauma victim of crime  discrimination  chronic health issues

family problems other:

Identify 3 strengths:

Identify 3 weaknesses:

What would you like to accomplish in therapy?

Is there anything else that is important for me to know?

Client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_