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

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:

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:

Have you had a concussion, seizure, or head injury? [ ] 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 dying, 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 | [ ]  | [ ]  |  |  |
|  |  |  |  |  |

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

Describe:

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

[ ] less than 1x/mo [ ] none 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:

What is your education background?

What is your work situation?

Family Income category: [ ]  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

Describe your strengths:

Describe your weaknesses:

Why do you want therapy at this time:

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_