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Information form:

Name: ________________________________ Birth date: ________________ Date: ______________

Describe the problem(s) that brought you here today:

Personal Information:
How would you describe yourself?

Check any of the symptoms that you are having:

- ☐ Extreme sadness and tearful
- ☐ Trouble concentrating
- ☐ Memory problems
- ☐ Changes in eating habits
- ☐ Feeling of extreme happiness
- ☐ Trouble performing your job
- ☐ Lack of enjoyment of usual activities
- ☐ Self-esteem problems
- ☐ Perfectionism
- ☐ Obsessions or compulsions
- ☐ Feeling fearful
- ☐ Physical complaints of pain
- ☐ Feeling tearful
- ☐ Change in sleeping habits
- ☐ Lack of energy
- ☐ Weight changes
- ☐ Excessive anxiety or worry
- ☐ Problems getting along with friends or family
- ☐ Feeling stressed
- ☐ Easily irritated
- ☐ Feeling guilt
- ☐ Feeling nervous
- ☐ Sudden feelings of panic
- ☐ Muscle tension

Stressful Circumstances:
Have you experienced any stress recently? (examples: conflict with family/friend, financial problems, death, divorce, illness) If yes, please explain when, what, and how it is affecting your daily functioning:

Have you ever been abused? (physically or sexually)
Is it still going on? If yes, please explain:

Do you have thoughts of hurting yourself or others?
If yes, do you have a plan?

Medical & Health information:

Primary Care Physician: ______________________________ Phone: ________________________
Specialists (e.g. endocrinologist, psychiatrist, psychologist, etc.) ____________________________
____

Month & year of diagnosed illness:____
____

Medications (current & past):____
____

Previous health problems and/or concerns: ____
____

Admission to hospital for any reason: no yes
If yes: Date(s):______________________________ Place:_____________________________
Contact person: ______________________________ Reason:____________________________

Emergency room visit for any reason: no yes
If yes: Date(s):______________________________ Place:_____________________________
Contact person: ______________________________ Reason:____________________________

Counseling with a mental health professional: no yes
If yes: Date(s):______________________________ Place:_____________________________
Contact person: ______________________________ Reason:____________________________

How would you describe your diet? (Healthy, Average, Needs some help)

How often do you exercise? What types of activities do they do?

How would you describe your sleeping habits? How many hours of sleep do you typically get?

Education & Employment:

Circle highest grade or level currently completed by:

Self:

1	2	3	4	5	6	7	8	9	10	11	12	Some College	BA/BS	MA/MS	MD/JD/PhD

Partner:

1	2	3	4	5	6	7	8	9	10	11	12	Some College	BA/BS	MA/MS	MD/JD/PhD

Occupation (self) :____ Hours per week: ____________

Occupation (partner):____ Hours per week: ____________

Client's Current School/Employer:____

What do you do?

Do you like what you do?

Do you have any problems there?

Friendships/support and activities:

Do you have a strong support group or friendships?

What are some of the hobbies or activities that you enjoy?

Do they help decrease stress?

Religion & other affiliation information:

Religious denomination:____________________ Other affiliation:_________________________________

☐ Never ☐ Sometimes ☐ Frequently ☐ Always

Attendance:Family Information:

Current marital/relationship status (check all that apply):

- ☐ Single
- ☐ Relationship with: ______________________________ Year: __________
- ☐ Married to: _______________________________ Year: __________
- ☐ Separated from: _______________________________ Year: __________
- ☐ Divorced from: _______________________________ Year: __________
- ☐ Widowed by: _______________________________ Year: __________

Do you have any children from this relationship?
If yes, what are their names & ages:

How would you describe your current relationship?

Have you had other significant relationships and/or been married before?
If yes, do you have any children from that relationship?

Is there anything you would like to add about this relationship?

Please list others in household:

Name:	Sex:	Age:	Relationship to client:
__________________________	______	______	__________________________
__________________________	______	______	__________________________
__________________________	______	______	__________________________

Parent(s) (please list names and describe relationship with them)

How would you describe your parents' relationship?

How many siblings do you have? (please list names and describe relationship with them)

Family Medical History:
Has any family member had any of the following? If yes, who, when and how were they treated?

Anxiety/Panic: ____
Obsessions/Compulsions: ____
Substance abuse: ____
Depression/mood swings: ____
Anger/aggression: ____
Schizophrenia: ____
Suicidal behavior: ____
Other conditions: ____
Any major illness: ____

Additional Information:
What worries or upsets you?

What makes you happy?

What would you like to see happen or change in therapy?