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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:

- ☐ Depression
- ☐ Extreme sadness
- ☐ 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
- ☐ Problems with anger
- ☐ Feeling hopeless
- ☐ 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
- ☐ Acting violently

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

Received by: _____ Date: _____

Medical & Health information:

How would you describe your diet?

- ☐ Healthy (I eat pretty good)
- ☐ Average (I probably need to change some things)
- ☐ Needs some help (I eat a lot of junk food)

How often do you exercise?

- ☐ Daily
- ☐ 3-5 times a week
- ☐ 1-2 times a week
- ☐ Less than once a week

Previous and current health problems or illnesses:

Previous and current medications:

Employment:

Where do you work? _____ How many hours a week? _____

What do you do?

Do you like what you do?

Do you have any problems there?

Relationship Information:

Are you married?

If yes, to whom: _____ when (date): _____

Do you have any children from this marriage?

If yes, what are their names & ages:

Have you been married before?

If yes, do you have any children from that marriage?

Do you have children from another relationship?

Do you currently have a significant other?
If yes, please describe your relationship:

Family Information:
Parent(s) (please list names, ages, and where they are currently living)

How would you describe your parents' relationship?

Are you adopted?

How many siblings do you have? (please list names, ages, and where they live now)

Describe your relationship with the following:

Parents/step-parents/guardians:

Brothers and/or sisters:

Extended family (grandparents, aunts, uncles, cousins)

Family 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?