Identifying Information & Treatment Goals

Name: ____ Date: __________

Address: ____

City: ___________________________ State: ________ Zip: ____________

Home Phone: ___________________________ Cell Phone: __________________________

Work Phone: ___________________________ E-Mail: ____________________________

Which number would you prefer I use?________________ OK to leave messages? ______

Date of Birth: ___________________________ Ethnicity: ___________________________

Marital Status: ________________________

Name and phone of an emergency contact ____

Who referred you? ____

Why are you seeking help at this time?

____

____

What are your goals in seeking help (please be as specific as possible)?

1. ____
2. ____
3. ____

If you achieved these goals, how would your life be different?

____

____

What have you already tried to solve the current problem that you're having?

____

____

Are you currently diagnosed with a mental health condition? _____ Yes _____ No

If Yes, what is/are the diagnosis(es)? ____

Have you in the past been diagnosed with a mental health condition? _____ Yes _____ No

If Yes, what was/were the diagnosis(es)? ____

Do you have any addictions? _____ Yes _____ No

If Yes, please specify ____

Present & Past Concerns

Please check any of the following that you have experienced – currently or in the past – & briefly describe:

Current Past

Symptom Concerns

____ _____ Anxiety____
____ _____ Depression ____
____ _____ Bad Nerves____
____ _____ Anger ____
____ _____ Stress related health problems____
____ _____ Low Energy/Fatigue____
____ _____ Appetite/Eating Problems____
____ _____ Sleep Disturbance____
____ _____ Obsessive/Ruminating Thoughts____
____ _____ Compulsive/Ritualistic Behaviors____
____ _____ Trouble thinking, concentrating, remembering__________________________________
____ _____ Fears ____
____ _____ Hearing voices or seeing things that aren't there ________________________________
____ _____ Odd thoughts or ideas that others find bizarre_________________________________
____ _____ Racing Thoughts____
____ _____ Thoughts of Death or Suicide____
____ _____ Suicide Attempts ____
____ _____ Thoughts of Violence____
____ _____ Alcohol Use ____
____ _____ Drug Use ____
____ _____ Other Addictions____
____ _____ Eating Disorders____
____ _____ Other ____

Social or Environmental Concerns

____ _____ Family Problems____
____ _____ Relationship Problems____
____ _____ Sexual Problems ____
____ _____ School/Work Problems____
____ _____ Financial Problems ____
____ _____ Legal Problems____
____ _____ Religious/Spiritual Problems____
____ _____ Social Problems/Problems getting along with people_____________________________
____ _____ Other ____

Background History

Child & Family History

Please describe a little bit about growing up in your family: ____

____

____

Did you experience any of the following?
____ Physical Abuse
____ Sexual Abuse
____ Psychological Abuse (Verbal/Emotional Abuse)
____ Neglect
____ Other Traumatic Events ____

____ Any traumatic events in childhood that occurred outside the home _____________________________

____

____ Any traumatic events in adulthood? ____

____

____ No history of abuse or traumatic events

Is there any family history of…
____ Domestic Violence
____ Alcohol/ Drug Abuse
____ Mental Illness

Educational & Vocational History

Highest grade/degree completed _________ Name of School ________________________________

Do you have any history of learning difficulties, learning disorder, or behavior problems in school?

_____ Yes _____ No If Yes, please describe ____

What is your current occupation? ____

What are your past occupations? ____

In what hobbies, activities, volunteer work, etc. are you active? ____________________________________

____

Medical History

Do you have any current medical conditions (including head trauma, thyroid or other hormonal conditions, GI problems, headaches/migraines)? _____ Yes _____ No

If YES, list doctor and phone number____

If YES, what condition(s)?: ____

____

If YES, what medication and/or treatments are you receiving for this? ______________________________

____

Please list any significant past medical conditions and/or treatments ___________________________________

____

Please list your primary physician & phone number ____

How many servings of caffeine do you have daily (1serving = 8oz coffee/tea or 12 oz soda)? _______________

FOR WOMEN – Does your menstrual cycle significantly affect your moods and/or level of anxiety? _________

Resources

Traditional Treatments

Please check any of those you have used – currently or in the past – and rate how helpful it has been to you
Rate 0-10: 0 = not at all → 10 = extremely

Current Past Rate

_____ _____ **Psychotherapy** _____

Approximate dates & type: ____

_____ _____ **Psychiatric Medications** _____

Current Psychiatrist & Phone Number ____________________________________

Current Meds & Dosage:____

Past Medications used: ____

_____ _____ **12 Step Programs** _____

Approximate dates & type of program: ____________________________________

_____ _____ **None of the above**

Have you ever had a psychiatric hospitalization? _____ Yes _____ No

If YES, approximate dates & name of hospital(s): ____________________________

Have you ever been in a residential treatment program? _____ Yes _____ No

If YES, approximate dates & name of program(s): ____________________________

Complementary and/or Alternative Treatments:

Please check any of those you have used – currently or in the past – and rate how helpful it has been to you
Rate 0-10: 0 = not at all → 10 = extremely

Current	Past		Rate	Current	Past		Rate
_____	_____	Herbs (e.g., St. John's Wort)	_____	_____	_____	Homeopathy	_____
_____	_____	Yoga/Pilates/Tai Chi	_____	_____	_____	Exercise	_____
_____	_____	Chinese Medicine	_____	_____	_____	Acupuncture	_____
_____	_____	Meditation	_____	_____	_____	Chiropractic	_____
_____	_____	Relaxation Exercises		_____	_____	Prayer	_____

_____ _____ Other: ____ _____

_____ _____ None

Religion & Spirituality:

Do you consider yourself a religious or spiritual person? ____________________________

How important is your faith, spirituality or religion to you *(Rate 0-10: 0 = not at all; 10 = extremely)?* ______

What faith do you consider yourself? ____________________________________

Are you a member of a spiritual or religious community or church? ______________________

The Final Word

Is there anything else that you would like me to know about you as we begin our work together?

____

____