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The information requested on this form is intended to be helpful to you and your therapist in the provision of the best possible service to you. If there is any question that you would prefer not to answer, please feel free to leave blank and discuss in session.

FULL NAME: _____
Name you prefer to be called: _____

PRESENTING PROBLEM

1. What is/are the reason(s) you are seeking therapy today? _____
_____

2. Did a specific event lead to this request for service? ☐ Yes ☐ No
If yes, please describe the incident. _____
_____

3. Please describe what you hope to accomplish in this therapy or what you hope will be different in your life as a result of attending therapy. _____
_____

4. How long has the problem been present? _____

5. What solutions to the problem have you tried, and what were the results? _____
_____

6. How much does this problem affect your life? (Please circle the number that best applies)

	Not at all	A little bit	A lot	All the time
Personally	0	1 2 3	4 5 6 7	8 9 10
Family Life	0	1 2 3	4 5 6 7	8 9 10
Socially	0	1 2 3	4 5 6 7	8 9 10
Work-wise	0	1 2 3	4 5 6 7	8 9 10

7. How were you referred to this service? (Please circle)

Self	Spouse/Other	Psychiatrist	Physician
Employer	Website	Phonebook Ad	Court

Other (please specify) _____

8. Do you make use of any community-based support groups (e.g. 12-Step Programs, social support groups, etc.)? ☐ Yes ☐ No
If yes, please specify _____

9. Please look these items over and circle the number that best describes how these symptoms have bothered you **recently**.

	Not at all	Mildly	Moderately	Severely
1. Depressed, sad, or crying	0	1 2 3	4 5 6 7	8 9 10
2. Guilty feelings	0	1 2 3	4 5 6 7	8 9 10
3. Suicidal thoughts, plans, or attempts Have you ***ever*** thought about, planned or attempted suicide? Thought about (Y or N) Planned (Y or N) Attempted (Y or N) If yes to any of these, when was this?	0	1 2 3	4 5 6 7	8 9 10
4. Changed sleep patterns □ Difficulty falling asleep □ Difficulty staying asleep □ Can't get up in the morning □ Nightmares	0	1 2 3	4 5 6 7	8 9 10
5. Change in weight or eating habits? □ Increase □ Decrease	0	1 2 3	4 5 6 7	8 9 10
6. History of restrictive eating, dieting or purging	0	1 2 3	4 5 6 7	8 9 10
7. Insecurity or inferiority	0	1 2 3	4 5 6 7	8 9 10
8. Loss of interest or energy in pleasurable activities	0	1 2 3	4 5 6 7	8 9 10
9. Anxious, nervous or panicky feelings	0	1 2 3	4 5 6 7	8 9 10
10. Avoiding places or situations	0	1 2 3	4 5 6 7	8 9 10
11. Repetitive thoughts of behaviors	0	1 2 3	4 5 6 7	8 9 10
12. Change in work habits □ Increase □ Decrease	0	1 2 3	4 5 6 7	8 9 10
13. Change in spending habits □ Increase □ Decrease	0	1 2 3	4 5 6 7	8 9 10
14. Anger or temper problems	0	1 2 3	4 5 6 7	8 9 10
15. Flashbacks or intrusive memories	0	1 2 3	4 5 6 7	8 9 10
16. Physical problems, pain or illness	0	1 2 3	4 5 6 7	8 9 10
17. Sexual worries or problems	0	1 2 3	4 5 6 7	8 9 10
18. Brain fog, fuzzy thinking or dissociation	0	1 2 3	4 5 6 7	8 9 10
19. Memory problems	0	1 2 3	4 5 6 7	8 9 10
20. Confused or disorganized thoughts	0	1 2 3	4 5 6 7	8 9 10
21. Periods of high energy/activity with less need for sleep	0	1 2 3	4 5 6 7	8 9 10

10. Do any of the following concerns contribute to your symptoms(s)? (Please circle)

Family move to a new home	Financial Stress	Relationship Difficulties
Post-divorce adjustment	Spiritual problems	Marital unfaithfulness
Parenting Problems	Adjustment to school	Death of a family member
Adjustment to a new job	Career concerns/unemployment	Compulsive gambling/spending
Dishonesty	Developmental problems	Other:
Known physical/sexual abuse	Alcohol/Substance abuse	
Pornography use	Anger/Violence	
Birth of child or sibling	Empty nest	

11. Who is your family physician/psychiatrist? _____

_____

12. Who else do you regularly see as part of your routine health care? _____

_____

_____

13. Have you ever taken any medications for depression, anxiety, or mental health concerns?
□ Yes □ No If yes, please list:

Medication	**Dose and number of pills you take per day**	**Prescribing Doctor**

14. Are you currently taking any medications other than those listed above?
□ Yes □ No If yes, please list:

Medication	**Dose and number of pills you take per day**	**Prescribing Doctor**

15. Do you have any allergies to medications? □ Yes □ No
If yes, please list: _____

16. Have you ever been hospitalized for mental health concerns? _____
_____
_____
_____

17. Have you ever experienced any of the following as a result of substance use? (Please circle)

Blackouts	Bad reactions	Withdrawal symptoms	Overdose	DUI	Other

18. Have you ever felt you should cut down on your drinking or drug use? □ Yes □ No
19. Have people annoyed you by criticizing your drinking or drug use? □ Yes □ No
20. Have you ever felt bad or guilty about your drinking or drug use? □ Yes □ No
21. Have you ever had a drink or used drugs as an eye-opener first thing in the morning to steady your nerves, or get rid of a hangover or to get the day started? □ Yes □ No
22. Have you ever had treatment for any type of alcohol or substance use? □ Yes □ No

23. What has helped you manage or endure your current problem? _____
_____

24. Please describe the people in your life that currently play a supportive, influential, or friendship role. _____
_____
_____

25. What interests or passions give meaning to your life? _____
_____

26. Do you have any spiritual beliefs or practices that are important to you? _____
_____

27. What aspects of your culture, heritage, or ethnicity would you like your therapist to be aware of?
_____
_____

28. Is there anything else that you would like your therapist to know that you have not written on any of these forms? _____
_____
_____

I acknowledge that the information on this form is accurate to the best of my knowledge, and that I will inform Marilyn Webb of any changes in my personal circumstances including address, symptoms experienced, suicidal thoughts and substance use.

If you think it would be helpful for your therapist to contact a previous therapist or physician, you will need to sign a Release Of Information form.

Client Signature: _____
Date: _____