

Please describe, the problem(s)/symptom(s) that bring you into counseling today:

Have you ever had a problem like this before (circle one)? **YES NO**
If YES, when did it happen and how did you deal with it?

Check the following that you may be experiencing:

- | | |
|--------------------------|-----------------------------|
| <input type="checkbox"/> | Dissatisfied with Life |
| <input type="checkbox"/> | Can't Make Decisions |
| <input type="checkbox"/> | Feeling Stuck |
| <input type="checkbox"/> | Worried / Nervous |
| <input type="checkbox"/> | Lack of Motivation |
| <input type="checkbox"/> | Unable to Focus |
| <input type="checkbox"/> | Feelings of Inferiority |
| <input type="checkbox"/> | Appetite Problems |
| <input type="checkbox"/> | Sense of Failure |
| <input type="checkbox"/> | Forgetfulness |
| <input type="checkbox"/> | Sleep Problems |
| <input type="checkbox"/> | Cheating / Infidelity |
| <input type="checkbox"/> | History of Being Abandoned |
| <input type="checkbox"/> | Over-Ambitious / Workaholic |

- | | |
|--------------------------|-------------------------------|
| <input type="checkbox"/> | Sad or Depressed Feelings |
| <input type="checkbox"/> | Angry Feelings |
| <input type="checkbox"/> | Recurring Thoughts |
| <input type="checkbox"/> | Feeling Disconnected |
| <input type="checkbox"/> | Thinking About the Past |
| <input type="checkbox"/> | Recent Death or Loss |
| <input type="checkbox"/> | Caring for Sick or Elderly |
| <input type="checkbox"/> | Loneliness |
| <input type="checkbox"/> | Sexual Problems |
| <input type="checkbox"/> | Addictive Behaviors |
| <input type="checkbox"/> | Secret Behaviors |
| <input type="checkbox"/> | Not Feeling Understood |
| <input type="checkbox"/> | Don't Like to be Alone |
| <input type="checkbox"/> | Difficulty Controlling Temper |

Have you experienced physical, sexual or emotional abuse (circle one)? **YES NO**
If YES, when?

Have you ever had a physical fight with your spouse or partner - such as throwing things, shoving, or hitting (circle one)? **YES NO**
If YES, please explain specifically:

Have you ever physically harmed anyone (circle one)? **YES NO**
If YES, please describe:

Have you ever been arrested for a crime (circle one)? **YES NO**
If YES, please explain:

In the past, have you ever contemplated or attempted suicide (circle one)? **YES NO**
If YES, please give dates and circumstances:

Has anyone in your family ever attempted suicide (circle one)? **YES NO**
If YES, please identify family member.

Has anyone in your family been diagnosed with a psychological or emotional problem (circle one)? **YES NO**
If YES, please specify:

Has anyone in your immediate family had a substance use or abuse problem (circle one)? **YES NO**
If YES, who, what problem, when?

Have you ever been in psychotherapy or counseling (circle one)? **YES NO**
If YES, give dates & type:

Are you currently employed? **YES NO**
If yes, what is your current employment situation?

Do you enjoy your work? Is there anything stressful about your current work?

What do you consider to be some of your strengths?

What do you consider to be some of your weaknesses?

What would you like to accomplish out of your time in therapy?

MEDICAL INFORMATION – CHECK ALL THAT APPLY

- ADD
 - ADHD
 - Anorexia
 - Anxiety
 - Back Problems
 - BiPolar Disorder
 - Bulimia
 - Cancer (Please Specify Type and if in remission or undergoing treatment)
 - Chronic Pain
 - Colitis
 - Concussion or Brain Trauma
 - Depression
 - Diabetes
 - Epilepsy
 - Fibromyalgia
 - Heart Disease
 - Hearing Problems
 - HIV/AIDS
 - Kidney Problems (if yes, are you on dialysis?) Liver problems or pancreatitis?
 - Lupus
 - Medical Treatment for Addiction (e.g., Methadone, Vivitrol)
 - Multiple Sclerosis
 - Neurological Disorders
 - Other Sexually Transmitted Diseases (please specify)
 - Schizophrenia
 - Others not listed
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- List all prescription medication:
-

Substance Use:

- Alcohol – Amount & Frequency: _____
- Cigarettes – Amount & Frequency: _____
- Marijuana – Amount & Frequency: _____
- Methamphetamines – Amount & Frequency: _____
- Cocaine – Amount & Frequency: _____
- Ecstasy – Amount & Frequency: _____
- Opiate / Heroin – Amount & Frequency: _____