

12. Other family members (parents, siblings) not listed above:

Name	Relationship	Age	Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

13. Medical History:

Present Medication: _____

Serious Illnesses: _____

Disabilities: _____

14. Have you ever sought therapy before?

Name of provider(s): _____

Location: _____

Focus of Therapy: _____

15. Areas of Concern:

15a. For what difficulties or concerns are you seeking therapy?

15b. How much of your concerns are affecting your ability to function effectively?

- I am immobilized
- My concerns affect my functioning most of the time
- My concerns affect my functioning often
- My concerns affect my functioning from time to time
- My concerns do not affect my functioning at all

15c. How much trouble are you having coping with your concerns?

- I find it difficult to cope at all
- I have difficulty coping most of the time
- I have difficulty coping often
- I have difficulty coping from time to time
- I rarely, if ever, have difficulty coping

16. What lead to your deciding to seek therapy at this particular time?

17. Please check any of the following areas in which you are experiencing difficulty.

- | | | | |
|-----------------------------------|----------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Abuse | <input type="checkbox"/> Eating | <input type="checkbox"/> Mood Shifts | <input type="checkbox"/> Self-esteem |
| <input type="checkbox"/> Academic | <input type="checkbox"/> Health | <input type="checkbox"/> Relationship | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Legal | <input type="checkbox"/> Sexual | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Career | <input type="checkbox"/> Loss | <input type="checkbox"/> Sexuality | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Children | <input type="checkbox"/> Marital | <input type="checkbox"/> Sleep | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Drugs | <input type="checkbox"/> Meaning | <input type="checkbox"/> Social Skills | <input type="checkbox"/> _____ |

When you have finished checking the areas of difficulty, place an asterisk (*) beside one, two, or three that are most important.

18. Have you had self-destructive/suicidal thoughts? Yes No

19. Have you had any unwanted sexual experiences? Yes No

20. Have you had any significant legal problems? Yes No

21. Have you had trouble controlling behavior related to alcohol, drugs, food, sex, gambling, smoking, etc.? Please indicate which, if any, apply.

22. Is there anything about your family history (e.g. alcoholism, divorce, mental health) that the therapist might find helpful to know?

23. Please check any of the following feelings that you are struggling with.

- | | | | |
|------------------------------------|------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Afraid | <input type="checkbox"/> Betrayed | <input type="checkbox"/> Hopeless | <input type="checkbox"/> Panicked |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Confused | <input type="checkbox"/> Isolated | <input type="checkbox"/> Self-destructive |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Depressed | <input type="checkbox"/> Jealous | <input type="checkbox"/> Stressed |
| <input type="checkbox"/> Apathetic | <input type="checkbox"/> Guilty | <input type="checkbox"/> Numb | <input type="checkbox"/> Worried |
| <input type="checkbox"/> Ashamed | <input type="checkbox"/> Helpless | <input type="checkbox"/> Overwhelmed | <input type="checkbox"/> _____ |

When you have finished checking the relevant feelings above, place an asterisk (*) beside one, two, or three that are most important.

24. How would you like to be different after therapy; that is, what is your goal?

25. What kind of help are you anticipating from a therapist?

26. Support

26a. To what extent do you have an available support network of family and friends with whom you can discuss personal concerns?

- I have many individuals available with whom I can talk
- I have several individuals available with whom I can talk
- I have a few individuals available with whom I can talk
- I have no individuals available with whom I can talk

27. Please list activities you engage in for fun and recreation.

This office has a 24-hour cancellation policy. You will be billed for an appointment cancelled without 24-hour prior notice.

Signature of Client

Date

Signature of Therapist

Date