Name ____

Address ____

Phone ____

Date of Birth __________________

Occupation/School ____

Emergency Contact Person and number____

Partner/relationship Status ____

Who referred you to me? ____

What brings you to counseling today? ____

Are you currently seeing a Psychiatrist? Yes ____ No ____

Are you currently taking any medications? Please list : _____________________________

____

Have you ever been hospitalized? ____

Have you had previous counseling? ____

Was it helpful? ____

Have you had any suicide attempts, self-destructive behaviors, or violent behaviors? ________

____

Please list any past/present drug or alcohol use. Are you currently using and how much? Has it affected your work or your relationships? ____

____

Currently, what are your main worries or fears? ___________________________________