Name: _____ DOB:_____ Age:_____

Address: _____ City/Zip:_____

Home Phone: _____ Cell Phone:_____

Email: _____

Emergency Contact Name:_____ Relationship:_____

Phone Number:_____ Email Address:_____

Address:_____ City/Zip:_____

Relationship Status: □ Married □ Single □ Divorced □ Separated
□ Widowed □ Never Married □ Remarried □ Cohabitating

If Single are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

1. Are you currently employed? □_No □_Yes

If yes, what is your current employment situation?

_____

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

_____

_____

3. What do you consider to be some of your strengths?

_____

_____

_____

4. What do you consider to be some of your challenges?

_____

_____

_____

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

_____

_____

_____

6. Are you currently experiencing overwhelming sadness, grief or depression?
□ No □ Yes

If yes, approximately how long?_____

7. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No □ Yes

If yes, when did you begin experiencing this? _____

8. Are you currently experiencing any chronic pain? If so where?
□ No □ Yes

If yes, please describe_____

9. Do you drink alcohol more than once a week?
□ No □ Yes What type of alcohol:_____ How often:_____

10. How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

What drugs do you use recreationally? _____

11. What significant life changes or stressful events have you experienced recently:

_____

Referred by: □ Friend/Family □ Internet □ Website □ Psychiatrist/Therapist □ Other