Therapy Help Center

New Patient Form

Date: _____ Name: _____

Date of Birth: _____ Age: _____

PRESENTING ISSUES AND CONCERNS

Describe the issues and concerns that brought you to seek therapy:

_____

_____

_____

Please check all of the issues and concerns that apply to you:

- ☐ Distractibility
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Boredom
- ☐ Poor memory/confusion
- ☐ Seasonal mood changes
- ☐ Sadness/depression
- ☐ Loss of pleasure/interest
- ☐ Hopelessness
- ☐ Thoughts of death
- ☐ Self-harm behaviors
- ☐ Crying spells
- ☐ Loneliness
- ☐ Low self-worth
- ☐ Guilt/shame
- ☐ Fatigue
- ☐ Other: _____
- ☐ Change in appetite
- ☐ Lack of motivation
- ☐ Withdrawal from people
- ☐ Anxiety/worry
- ☐ Panic attacks
- ☐ Fear of leaving home
- ☐ Social discomfort
- ☐ Obsessive thoughts
- ☐ Compulsive behavior
- ☐ Aggression/fights
- ☐ Frequent arguments
- ☐ Irritability/anger
- ☐ Homicidal thoughts
- ☐ Flashbacks
- ☐ Hearing voices
- ☐ Visual hallucinations
- ☐ Suspicion/paranoia
- ☐ Racing thoughts
- ☐ Excessive energy
- ☐ Wide mood swings
- ☐ Sleep problems
- ☐ Nightmares
- ☐ Eating problems
- ☐ Gambling problems
- ☐ Computer addiction
- ☐ Problems with pornography
- ☐ Parenting problems
- ☐ Sexual problems
- ☐ Relationship problems
- ☐ Work/school problems
- ☐ Alcohol/drug use
- ☐ Recurring, disturbing memories

Are your problems affecting any of the following?

- ☐ Handling everyday tasks
- ☐ Work/School
- ☐ Recreational activities
- ☐ Self-esteem
- ☐ Housing
- ☐ Sexual activity
- ☐ Relationships
- ☐ Legal matters
- ☐ Health
- ☐ Hygiene
- ☐ Finances

☐ Yes ☐ No Have you ever had thoughts, made statements, or attempted to hurt yourself? If yes, please describe: _____

_____

☐ Yes ☐ No Have you ever had thoughts, made statements, or attempted to hurt someone else? If yes, please describe: _____

_____

☐ Yes ☐ No Have you recently been physically hurt or threatened by someone else? If yes, please describe: _____

_____

_____

THERAPIST NOTES

Therapy Help Center

Name: _____

FAMILY AND DEVELOPMENTAL HISTORY

Relationship	Name	Age	Quality of Relationship	Family Mental Health Problems	Who?
Mother				Hyperactivity	
Father				Sexual Abuse	
Stepmother				Depression	
Stepfather				Manic Depression	
Siblings				Suicide	
				Anxiety	
				Panic Attacks	
Spouse/partner				Obsessive-Compulsive	
Children				Anger/Abusive	
				Schizophrenia	
				Eating Disorder	
				Alcohol Abuse	
				Drug Abuse	

☐ Parents legally married or living together
☐ Parents temporarily separated
☐ Parents divorced or permanently separated

☐ Mother remarried: Number of times _____
☐ Father remarried: Number of times _____

Please check if you have experienced any of the following types of trauma or loss:

☐ Emotional abuse
☐ Sexual abuse
☐ Physical abuse
☐ Parent substance abuse
☐ Teen pregnancy
☐ Neglect
☐ Violence in the home
☐ Crime victim
☐ Parent illness
☐ Placed a child for adoption
☐ Lived in a foster home
☐ Multiple family moves
☐ Homelessness
☐ Loss of a loved one
☐ Financial problems

PREVIOUS MENTAL HEALTH TREATMENT

Yes	No	Type of Treatment	When?	Provider/Program	Reason for Treatment
		Outpatient Counseling			
		Medication (mental health)			
		Psychiatric Hospitalization			
		Drug/Alcohol Treatment			
		Self-Help/Support Groups			

THERAPIST NOTES

Therapy Help Center

Name: _____

SUBSTANCE USE HISTORY

Substance Type	Current Use (last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
Ecstasy								
Heroin								
Inhalants								
Methamphetamines								
Pain Killers								
PCP/LSD								
Steroids								
Tranquilizers								
Other: _____								

☐ Yes ☐ No Have you had withdrawal symptoms when trying to stop using any substances? If yes, please describe: _____

_____

☐ Yes ☐ No Have you ever had problems with work, relationships, health, the law, etc. due to your substance use? If yes, please describe: _____

_____

THERAPIST NOTES

Therapy Help Center

Name: _____

MEDICAL INFORMATION

Date of last physical exam: _____

Have you experienced any of the following medical conditions during your lifetime?

- ☐ Allergies
- ☐ Chronic pain
- ☐ Dizziness/fainting
- ☐ High fevers
- ☐ Sexually Transmitted Infection
- ☐ Asthma
- ☐ Surgery
- ☐ Meningitis
- ☐ Diabetes
- ☐ Headaches
- ☐ Serious accident
- ☐ Seizures
- ☐ Hearing problems
- ☐ Sleep disorder
- ☐ Stomach aches
- ☐ Head injury
- ☐ Vision problems
- ☐ Other: _____

Is there anything about your health, past or present, that you'd like us to know about?
Please share whatever feels comfortable — you're welcome to include as much or as little as you wish.

Current prescription medications: ☐ None

Medication	Dosage	Date First Prescribed	Prescribed By

Current over-the-counter medications (including vitamins, herbal remedies, etc.):

_____

_____

_____

_____

THERAPIST NOTES

Therapy Help Center

Name: _____

INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Please describe your social support network (check all that apply):
☐ Family ☐ Neighbors ☐ Friends ☐ Students ☐ Co-workers ☐ Support/Self-Help Group

☐ Community Group ☐ Religious/Spiritual Center (which one? _____)

To which cultural or ethnic group do you belong? _____

If you are experiencing any difficulties due to cultural or ethnic issues, please describe:
_____

_____

Please describe your strengths, skills, and talents?
_____

Describe any special areas of interest or hobbies (art, books, physical fitness, etc.):
_____

_____

MISCELLANEOUS INFORMATION

Employment
Employer: _____ Position: _____
Length of time in this position: _____ Job Duties: _____
Stress level of this position: ☐ Low ☐ Medium ☐ High
Other jobs you have held: _____

Education
☐ Yes ☐ No Are you currently attending school?
☐ High School Graduate? Or ☐ GED? Year _____
☐ Associate's Degree Year _____ Major area of study _____
☐ Undergraduate Degree Year _____ Major area of study _____
☐ Graduate Degree Year _____ Major area of study _____

Military Service
☐ Yes ☐ No Have you been/are you currently in the military? (If no, skip remainder of this section)
Branch _____ Date of Discharge _____
Type of Discharge _____ Rank _____
☐ Yes ☐ No Were you in combat?

Legal
☐ Yes ☐ No Have you ever been convicted of a misdemeanor or felony? If yes, please explain
_____

☐ Yes ☐ No Are you currently involved in any divorce or child custody proceedings? If yes, please explain _____
_____

_____

THERAPIST NOTES