Date: _____ Name: _____

Date of Birth: _____ Age: _____

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:

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Name: _____

IN-DEPTH SESSION

Your In-Depth Session

These questions are for your In-Depth Session. I read and analyse your answers before we meet, so take your time and answer as fully as you wish. Return this form, with the Privacy Notice and Policy Agreement, at least five days before your session.

What is your home country? _____

Tell me about the kind of work you do and the challenges it creates.

Tell me about any prior therapy you have had. Was any of it clinical, one-on-one with a therapist? For how long?

Have you worked with a psychiatrist in the past, and are you on medication now?

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Name: _____

IN-DEPTH SESSION · CONTINUED

Your In-Depth Session

Tell me about your family, your family structure and your history with your family.

What is your support network like? Who would you call for help at 3 a.m., no questions asked?

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Name: _____

IN-DEPTH SESSION · CONTINUED

Your In-Depth Session

Who are you?

What do people say about you?

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Name: _____

IN-DEPTH SESSION · CONTINUED

Your In-Depth Session

Who do you want to be in two years?

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Name: _____

Family and Developmental History

Relationship	Their Name	Age	Quality of Relationship	Family Mental Health Problems	Which Family Member?
Mother				**Hyperactivity**	
Father				**Sexual Abuse**	
Stepmother				**Depression**	
Stepfather				**Manic Depression**	
Siblings				**Suicide**	
				Anxiety	
				Panic Attacks	
Spouse/partner				**Obsessive-Compulsive**	
Your 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			

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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	☐	☐			☐	☐		
Sedatives	☐	☐			☐	☐		
MDMA	☐	☐			☐	☐		
Heroin	☐	☐			☐	☐		
Inhalants	☐	☐			☐	☐		
Amphetamines	☐	☐			☐	☐		
Pain Killers	☐	☐			☐	☐		
Ayahuasca	☐	☐			☐	☐		
PCP/LSD	☐	☐			☐	☐		
Steroids	☐	☐			☐	☐		
Tranquilizers	☐	☐			☐	☐		
Other Not Listed _____ _____ _____	☐ ☐ ☐	☐ ☐ ☐			☐ ☐ ☐	☐ ☐ ☐		

☐ 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:

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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.):

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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.):

Additional 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 _____

Additional education information:

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Name: _____

Additional Information

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? If yes, please explain

Legal Issues

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

Divorce or Child Custody Issues

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

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