NAME: ____ **DATE:** ______________________

Ethnicity/Race:____

Gender: _____Female _____Male _____Non-binary_____AFAB_____AMAB_____Trans_____Other

I. PRESENTING PROBLEM

1. What is/are your reason(s) for coming today? ____
   ____
2. When did this problem begin? ____
3. How severe is this problem? (0 = no problem to 10 = worst possible) ________
4. Please check those areas which are currently sources of increased stress for you:

☐ marital ☐ social ☐ death ☐ medical ☐ military ☐ drug problems
☐ divorce ☐ peers ☐ loss ☐ legal ☐ alcohol problems
☐ family ☐ relationships ☐ trauma ☐ finances ☐ work ☐ other (explain): ________________

II. HEALTH HISTORY

1. Have you recently experienced any of the following? (please check all that apply):

☐ anger ☐ flashbacks ☐ hopeless ☐ mood swings ☐ rage
☐ anxiety ☐ guilt ☐ injury ☐ nightmares ☐ seeing visions
☐ appetite change ☐ headaches ☐ irritability ☐ numbness ☐ sleep problems
☐ chest pain ☐ hearing voices ☐ loss of energy ☐ pain ☐ slurred speech
☐ depression ☐ helpless ☐ low impulse control ☐ panic ☐ stomach trouble
☐ dizziness ☐ high blood pressure ☐ low/no interest ☐ paranoia ☐ stress
☐ eating problems ☐ high energy ☐ major illness ☐ poor concentration ☐ suicidal thoughts
☐ fatigue ☐ homicidal thoughts ☐ memory problems ☐ racing thoughts ☐ weight change
☐ other (explain) ____

2. Who is your primary care provider? ____
3. List **CURRENT** medications (include over-the-counter meds and supplements, use back of sheet if needed)

Name of Medication	What is it prescribed for?	When did you start taking?

4. Which of the following Complementary/Alternative practices or treatments do you use? (Check all that apply)

☐ Acupressure ☐ Acupuncture ☐ Chiropractic ☐ Meditation ☐ Massage
☐ Qi Gong ☐ Reiki/Energy Work ☐ Traditional Chinese Medicine (Herbs) ☐ Yoga

5. Do you smoke, vape, or use tobacco or nicotine products? ☐ Yes ☐ No Describe: ___________________________

6. Do you use any marijuana products? ☐ Yes ☐ No Describe: ____

7. How much caffeine (include energy drinks./supplements) do you use daily? ________________________________

8. Are you using alcohol/drugs at this time? ☐ Yes ☐ No Describe: _______________________________________

9. Have you previously experienced a mental health problem for which you received treatment? ☐ Yes ☐ No

10. Have you previously experienced a substance abuse problem for which you received treatment? ☐ Yes ☐ No

11. Have you ever been hospitalized for a psychiatric condition? ☐ Yes ☐ No

12. Have you ever gone to the Emergency Department for a psychiatric reason? ☐ Yes ☐ No

13. Have any of your biological family members ever been diagnosed or treated for: (please check all that apply)
    ☐ bipolar disorder ☐ suicidal thinking or attempt ☐ mania ☐ substance abuse ☐ depression
    ☐ schizophrenia ☐ violent behavior ☐ paranoia ☐ irritability ☐ anxiety
    ☐ other behavioral health ____

14. Did you experience any developmental delays during childhood?____

15. Do you currently have any significant health issues or chronic medical conditions?__________________________

16. Have you had any major surgeries?____

17. Have you ever engaged in any type of self-directed violence such as cutting or burning? ☐ Yes ☐ No

18. Have you ever tried to hurt yourself with the intent of ending your life? ☐ Yes ☐ No

III. NUTRITIONAL ASSESSMENT

1. Do you have any current problems with food or nutrition? ☐ Yes ☐ No
2. Which of the following best describes your current state of nutrition? (check one)
   ☐ Normal, healthy, no significant problems maintaining a healthy weight
   ☐ Have difficulty eating enough to keep weight in the normal range
   ☐ Have a tendency to gain weight easily if not careful
   ☐ Currently overweight
3. Do you take any nutritional supplements or vitamins? ☐ No ☐ Yes ___________________________________
4. Do you have any history of binge eating, purging, or restricting calories? ☐ No ☐ Yes ______________________

IV. SOCIAL SYSTEMS/SUPPORTS

1. Are you currently married or in a committed relationship? ☐ No ☐ Yes (How long)? ________
2. Is your relationship monogamous, polyamorous, or open?____________________________
3. How many times have you been married/in long term committed relationship? ___________

4. Please list the names, ages, and sex of your children if you have any.

Name	Age	Sex	Currently lives with

4. Where were you born/raised? ______________________________

5. Are your parents living?______________________________

6. Do you have any siblings? Please list______________________________

7. Have you recently withdrawn from friends or family? ◻ Yes ◻ No

8. Do you have any close friends that you feel like you can count on? ◻ Yes ◻ No

IV. SEXUALITY/REPRODUCTIVE HISTORY

1. Sexual identity: ◻ Heterosexual ◻ Gay/Lesbian ◻Bisexual ◻Pansexual ◻Other
2. Are you sexually active? ◻ Yes ◻ No
3. Do you use contraception? ◻ Yes ◻ No
4. Do you practice safe sex? ◻ Yes ◻ No
5. Are there any issues with sexual functioning, sexual preferences, or other related issues that you would like to discuss with the provider? ◻ Yes ◻ No

V. SPIRITUALITY/RELIGION HISTORY

1. Please check which of the below describes you the best:
   ◻ Religious and participate in a religious community
   ◻ Religious and do not attend a church or religious community regularly
   ◻ Believe in God (or Gods) but do not believe in “organized religion”
   ◻ Not sure/uncertain about spiritual beliefs
   ◻ No longer believe in a God (or Gods)
   ◻ Do not and have never believed in a God (Gods)

2. What is your religious preference/spiritual belief? ______________________________

VI. LEGAL HISTORY

1. Have you ever been arrested? ◻ Yes ◻ No Describe:______________________________

2. Do you have any current legal problems? ◻ Yes ◻ No Describe:______________________________

3. Did you have problems with discipline or conduct while you were growing up? ◻ Yes ◻ No

VII. EMPLOYMENT HISTORY

1. Are you currently working outside the home? ▫ No ▫ Yes

   If yes, where? ____

2. Please check any that apply to you:

   ▫ Job Stress
   ▫ Problems with supervisors or leadership
   ▫ Been laid off or fired from a job or position
   ▫ Problems with job performance
   ▫ Problems with co-workers

VIII. FINANCIAL STATUS

1. How would you describe your current financial status?

   ▫ Comfortable, finances are under reasonable control

   ▫ Stretched – having trouble making ends meet

   ▫ A real concern – overspending, overextended, or having problems with required payments, e.g., child support

   ▫ Facing severe financial problems – foreclosure, repossession, very heavy debt

2. Are there any other financial issues that are troubling you? ______________________________

IX. EDUCATIONAL HISTORY/LEARNING NEEDS ASSESSMENT

1. What kind of grades did you get in school? _________________
2. Did you ever repeat a grade? ▫ Yes ▫ No
3. Did you ever skip a grade? ▫ Yes ▫ No
4. Were you in Special Education? ▫ Yes ▫ No
5. Were you in any gifted & talented programs? ▫ Yes ▫ No
6. Are you currently in school? ▫ Yes ▫ No
7. How do you prefer to learn new information?________________________
8. Check as many as apply to you:

   ▫ GED ▫ HS diploma ▫ Vo-Tech Certificate ▫ College Courses/No degree

   ▫ AAS ▫ Bachelor's Degree ▫ Graduate courses/No degree ▫ Master's or above

X. QUALITY OF LIFE

1. How satisfied are you with: (Please check one box for each question)

   a. …your current family life?

   ▫ Very satisfied ▫ Satisfied ▫ Unsatisfied ▫ Very Unsatisfied

   b. ...support you receive from family/friends?

   ▫ Very satisfied ▫ Satisfied ▫ Unsatisfied ▫ Very Unsatisfied

   c. ...quality of life?

   ▫ Very satisfied ▫ Satisfied ▫ Unsatisfied ▫ Very Unsatisfied

   d. ...spirituality?

   ▫ Very satisfied ▫ Satisfied ▫ Unsatisfied ▫ Very Unsatisfied

e. ...financial situation?

▫ Very satisfied ▫ Satisfied ▫ Unsatisfied ▫ Very Unsatisfied

f. ...sex life?

▫ Very satisfied ▫ Satisfied ▫ Unsatisfied ▫ Very Unsatisfied

g. ...current occupation?

▫ Very satisfied ▫ Satisfied ▫ Unsatisfied ▫ Very Unsatisfied

2. During and after life's most stressful events, I handle it by: ____

____

3. Who do you usually talk to about your problems?____

4. Please describe or list your weaknesses or areas for improvement: ________________________________

____

5. Please list or describe your strengths: ____

____

7. Please describe your treatment goals:____

8. Who referred you to me or my practice?____