Date:_____

Initial Data From

Name:_____ Phone (Home):_____
Phone (Cell):_____
Address:_____

Age:_____ Date of Birth:_____ Sex:_____

Referred By:_____

Marital Status:_____ Occupation:_____

Race:_____ Education:_____

Person to Contact in an Emergency:_____

Instructions if therapist needs to contact you:
_____Can leave message stating her name and nature of call
_____Can leave message stating only name
_____Please do not leave a message

Past and Present Medical Problems: _____
_____
_____
_____

Current Medications:_____

Have you ever been abused?_____

Have you ever had an unusual, unpleasant, or frightening sexual experience?_____

Have you ever had suicidal thoughts?_____

Have you ever had an addiction/alcohol problem?_____

How often do you consume beer/alcoholic beverages?
Daily Weekly Monthly Less Frequently Never

How often do you use drugs?
Daily Weekly Monthly Less Frequently Never

Have you ever sought counseling in the past?_____

Have you ever had problems with weight/eating/concern over appearance?_____

Have any family members experienced psychological problems?_____

Current Problems: (circle all that apply)

Alcohol/Drugs

Concentration

Confusion about Beliefs

Loneliness

Pregnancy/Abortion

Shyness

Time Management

Stress Management

Sleep

Finances

Suicidal Thoughts

Academics

Depression

Sexual Concerns

Anxiety

Sexual Identity/Orientation

Unusual Thoughts/Experiences

Affair

Fear of Hurting Someone

Perfectionism

Health Problems/Disability

Procrastination

Sexual Abuse

Eating Problems (binging, vomiting, dieting)

Sexually Transmitted Disease
Headaches

Self-Esteem

Discrimination

Major Life Decision

Relationship Problems

Anger

Occupational Problems/Employment

Spiritual Concerns

Communication

Parenting

Other:_____