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Instructions: Each client is to complete one form, per person.

How did you hear about or find this office? *(circle any)*

a. Partner, Friend, Relative or Acquaintance b. Professional or healthcare provider: _____ (name/office) c. AliveCounseling.com d. PsychologyToday.com profile	e. Search engine f. Facebook.com g. Other: _____

Legal name (First Middle Last): _____

Birth date: _____ **Sex:** M F other

Physical Address: _____

Phone number(s):

Home #: _____ **Cell #:** _____ Work/Other #: _____	**Which #'s can we leave messages on?** (check any) ☐Home ☐Cell ☐Work/Other **OR** ☐None *Note: We will opt to use Cell as primary unless you indicate otherwise*

Email: _____

Can we add you to our email list (newsletter, events, workshops, etc.)? (about 1x/month) ☐Yes ☐No

Mailing Address: _____

Ethnicity: _____ Sexual orientation: _____

Relationship status: (circle one) Single Married Partnered/Committed Divorced Widowed Other

Educational status: (circle one) Full-time Part-time Not enrolled

Work status: (circle one) Full-time Part-time None

Employer name: _____

Employer address: _____

Names and phone numbers of all legal guardians or caregivers of client *(if applicable)*:

Emergency contact(s): *(by listing, you agree this office may contact the person in cases of emergency)*

Name: _____ Name: _____

Phone: _____ Phone: _____

Symptom checklist:

Please c*heck each symptom that you have experienced in the past year or have at least moderate concern about.*

Drug and Alcohol □ Alcohol use / abuse Type/Duration/Frequency: □ Marijuana use / abuse Type/Duration/Frequency: Have card? Y / N □ Drug use / abuse (+ prescription misuse) Type/Duration/Frequency: **Mental Health** □ Loss of interest in pleasurable activities □ Depression □ Thoughts or dreams of death or dying □ Suicidal thoughts □ Suicide attempt(s) □ Cutting or self-injury □ Hopelessness	□ Low self-esteem □ Worthlessness □ Crying easily □ Loneliness □ Grief or Loss □ Isolation or Withdrawal □ Change in energy □ Appetite or Weight change □ Sleeping issues □ Concentration issues □ Memory issues □ ADHD or ADD □ Agitation or Irritability □ Temper outbursts, Rage or Anger □ Impulses to injure people/destroy objects □ Racing thoughts □ Difficulty thinking or talking □ Poor judgment □ Impulsive behavior □ Stress	□ Anxiety or Nervousness □ Obsessions □ Compulsions □ Nightmares □ Panic Attacks □ Fears or Phobias □ Shyness □ Guilt □ Diet or Eating concerns □ Dissociation □ Low sexual desire □ Sexual inability / pain □ Sex addiction □ Pornography addiction □ Disturbing thoughts about sex □ Sexual abuse or assault □ Domestic Violence or Physical abuse □ Hallucinations □ Paranoia or Mistrust □ Difficult relationships □ Trouble making or keeping friends	□ Trust issues □ Financial difficulties □ School difficulties □ Job/career difficulties □ Legal issues □ Spiritual issues **Medical issues** □ Headaches or Migraines □ Chronic injury □ Chest pain / discomfort □ Heart attack(s) □ Stomach or intestinal issues □ Shortness of breath / Difficulty breathing □ Asthma / Allergies □ Dizziness □ Seizures □ Nausea □ Diabetes □ Obesity □ Other: _____

Medical information:

Physician: _____ Phone: _____

Psychiatrist: _____ Phone: _____

List current medications and dosages:

Please list any current medical, health, or mental health conditions, diagnoses, or treatment that you have had:

Is there anything else you wish to communicate on this form?

PLEASE SIGN

_____ X_____ _____

Client's printed name Client's signature Today's Date