Anchor Counseling and Wellness, LLC

Dawn I. Hooper, LCSW



**CLIENT INFORMATION FORM**

*\*This Form is Confidential\**

 **Today's date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Last First Middle Initial**

**Home street address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State:** \_\_\_\_\_\_\_**Zip:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of**

**Employer:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address of Employer:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State:** \_\_\_\_\_\_\_**Zip:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cell Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Calls will be discreet, but please indicate any restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referred by:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* May I have your permission to thank this person for the referral?

* If referred by another clinician, would you like for us to communicate with one another?

**Person(s) to notify in case of any emergency:** *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 **Name Phone**

 I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please briefly describe your presenting concern(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**What are your goals for therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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***\*\*The following information on this form will help guide your treatment. Please try to fill out as much as you are comfortable disclosing.\*\****

**MEDICAL HISTORY:**

Please explain any significant medical problems, symptoms, or illnesses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Current Medications:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Medication  | Dosage  |  Purpose  |  Name of Prescribing Doctor  |
|  |  |  |  |
|   |  |  |  |
|  |  |  |  |
|   |  |  |  |
|   |  |  |  |
|  |  |  |  |
|  |  |  |  |

 Do you smoke or use tobacco? YES NO If YES, how much per day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do you consume caffeine? YES NO If YES, how much per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do you drink alcohol? YES NO If YES, how much per day/week/month/year? \_\_\_\_

Do you use any non-prescription drugs? YES NO

If YES, what kinds and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have any of your friends or family members voiced concern about your substance use? YES NO

Have you ever been in trouble or in risky situations because of your substance use? YES NO

Previous medical hospitalizations (Approximate dates and reasons):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO

(Please list approximate dates and reasons): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Height \_\_\_\_\_\_\_\_\_ Weight (if applicable) \_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_ Gender \_\_\_\_\_\_\_\_\_

Sexual & Gender Identity: \_\_ Heterosexual \_\_Lesbian \_\_Gay \_\_Bisexual \_\_Transgender

 \_\_ Asexual \_\_ In Question \_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Racial/Ethnic Identity:

\_\_African/African-American/Black \_\_ Latino/Latino-American \_\_Bi-Racial/Multi-Racial

 \_\_American Indian/Alaska Native \_\_ Middle Eastern/Middle Eastern-American

 \_\_Asian/Asian-American/Asian Pacific Islander \_\_White/European-American \_\_Not listed

**FAMILY:**

How would you describe your relationship with your mother?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How would you describe your relationship with your father?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Page 3

Are your parents still married?\_\_\_\_\_\_\_\_\_\_\_\_\_ If they divorced, how old were you when they separated or divorced, and how did this impact you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many sisters do you have? \_\_\_\_\_\_ Ages? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many brothers do you have? \_\_\_\_\_\_ Ages? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you describe your relationships with your siblings? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:**

 POOR EXCELLENT

Currently in Relationship? \_\_\_\_ How Long? \_\_\_\_ Relationship Satisfaction: 1 2 3 4 5 6 7

Married/Life Partnered? \_\_\_\_\_ How Long? \_\_\_\_ Previously Married/Life Partnered? YES NO

 If so, length of previous marriages/committed partnerships\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have Children?\_\_\_\_ If YES, how many and what are their ages:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe any problems any of your children are having: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List the names and ages of those living in your household: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please briefly describe any history of abuse, neglect and/or trauma: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POOR EXCELLENT

Current level of satisfaction with your friends and social support: 1 2 3 4 5 6 7

Please briefly describe your coping mechanisms and self-care:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is spirituality important in your life and if so please explain:\_-

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Briefly describe your diet and exercise patterns:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**EDUCATION & CAREER**

High School/GED\_\_\_ College Degree\_\_\_ Graduate Degree(or Higher)\_\_\_ Vocational Degree\_\_\_ What is your current employment?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 POOR EXCELLENT

 Employment Satisfaction: 1 2 3 4 5 6 7

Any past career positions that you feel are relevant?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What do you think are your strengths?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Page 4 PLEASE CHECK ALL THAT APPLY & ***CIRCLE*** THE MAIN PROBLEM:

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  **DIFFICULTY WITH:** |  **NOW**  |  **PAST**  |  |  |  **DIFFICULTY WITH:**  |  **NOW**  |  **PAST**  |  |  | **DIFFICULTY WITH:**  |  **NOW**  |  **PAST**  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |
|  Anxiety  |   |   |  |  | People in General  |   |   |   |  | Nausea  |  |  |
|  Depression  |   |   |  |  |  Parents  |   |   |   |  | Abdominal Distress  |  |  |
|  Mood Changes  |   |   |  |  |  Children  |   |   |   |  | Fainting  |  |  |
|  Anger or Temper  |   |   |  |  | Marriage/Partnership  |   |   |   |  | Dizziness  |  |  |
|  Panic  |   |   |  |  |  Friend(s)  |   |   |   |  | Diarrhea  |  |  |
|  Fears  |   |   |  |  |  Co-Worker(s)  |   |   |   |  | Shortness of Breath  |  |  |
|  Irritability  |   |   |  |  |  Employer  |   |   |   |  | Chest Pain  |  |  |
|  Concentration  |   |   |  |  |  Finances  |   |   |   |  | Lump in the Throat  |  |  |
|  Headaches  |   |   |  |  | Legal Problems  |   |   |   |  | Sweating  |  |  |
|  Loss of Memory  |   |   |  |  | Sexual Concerns  |   |   |   |   |  Heart Palpitations  |  |  |
|  Excessive Worry  |   |   |  |  | History of Child Abuse |   |   |  |  | Muscle Tension  |  |  |
|  Feeling Manic  |   |   |  |  | History of Sexual Abuse  |   |   |  |  | Pain in joints  |  |  |
|  Trusting Others  |   |   |  |  | Domestic Violence  |   |   |   |  | Allergies  |  |  |
|  Communicating  |   |   |  |  | Thoughts of Hurting  |   |   |   |  | Often Make Careless  |  |  |
|  with Others  |   |   |  |  |  Someone Else  |   |   |   |  | Mistakes  |  |  |
|  Drugs  |   |   |  |  |  Hurting Self  |   |   |   |  | Fidget Frequently  |  |  |
|  Alcohol  |   |   |  |  | Thoughts of Suicide  |   |   |   |  | Speak Without Thinking  |  |  |
|  Caffeine  |   |   |  |  | Sleeping Too Much  |   |   |   |  | Waiting Your Turn  |  |  |
|  Frequent Vomiting  |   |   |  |  | Sleeping Too Little  |   |   |   |  | Completing Tasks  |  |  |
|  Eating Problems  |   |   |  |  | Getting to Sleep  |   |   |   |  | Paying Attention  |  |  |
|  Severe Weight Gain  |   |   |  |  | Waking Too Early  |   |   |   |  | Easily Distracted by Noises  |  |  |
|  Severe Weight Loss  |   |   |  |  |  Nightmares  |   |   |   |  | Hyperactivity  |  |  |
|  Blackouts  |   |   |  |  |  Head Injury  |   |   |   |  | Chills or Hot Flashes  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |

**FAMILY HISTORY OF (Check all that apply):**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Drug/Alcohol Problems  |  |  |   | Physical Abuse  |   |  |  |  Depression  |  |  |  |
| Legal Trouble  |   |  |   |  Sexual Abuse  |   |  |  |  Anxiety  |  |  |  |
| Domestic Violence  |   |  |   |  Hyperactivity  |   |  |  |  Psychiatric Hospitalization  |  |  |  |
| Suicide  |   |  |   | Learning Disabilities  |   |  |  |  “Nervous Breakdown”  |  |  |  |

**Any additional information you would like to include:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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