



## New Appointment Information

*Please complete all items to help in planning services for you.  
All information is kept confidential (see Notice of Privacy Practices).*

Full Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Pronouns: \_\_\_\_\_ Sex/Gender: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Email Address: \_\_\_\_\_

Phone: \_\_\_\_\_ May we leave a message and/or text? Y N

Racial/Ethnic Background: \_\_\_\_\_ Country of Origin: \_\_\_\_\_

Occupation/Employer: \_\_\_\_\_ Education Level: \_\_\_\_\_

How did you find out about this service? \_\_\_\_\_

What brings you here today? \_\_\_\_\_

1. Has anyone expressed concern about your:

\_\_\_\_Mood \_\_\_\_Risky Behavior \_\_\_\_Eating Behaviors \_\_\_\_Substance Use \_\_\_\_Other

2. Have you ever missed any practices/classes/work due to your presenting concerns? Y N

3. Are you engaging in self-harming behaviors? Y N

4. List all prescribed medications:

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

5. List any medications used that are not prescribed by a physician:

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



6. During the past 2 weeks what is the average number of days you drank alcohol each week:

0 1 2 3 4 5 6 7

a. Average number of drinks on each occasion:

\_\_\_\_\_

7. Have you recently had a traumatic experience?      Y      N

8. Have you ever been physically, emotionally, or sexually abused?      Y      N

9. Are you engaging in any of the following eating related behaviors:      Y      N

If yes, Type? \_\_\_\_\_ (i.e., Binging/Uncontrolled Eating, Purging, Restricting food intake, Regular Use of Laxatives)

10. Has there ever been a period when you were not your usual self and....

a. \_\_\_\_ You got much less sleep than usual and were not tired.

b. \_\_\_\_ You were much more active or did many more things than usual.

c. \_\_\_\_ You did things that other people might have thought were risky.

d. \_\_\_\_ You experienced extreme mood changes.

11. Have you ever seen or heard anything that other people couldn't see or hear?      Y      N

12. Have you had unusual experiences that other people might not believe?      Y      N

13. Prior mental health treatment and approximate ages:

a. Psychologist/Counselor: \_\_\_\_\_

b. Psychiatrist: \_\_\_\_\_

c. Hospitalizations: \_\_\_\_\_

d. Medications: \_\_\_\_\_



**14.** Do you have biological relatives with any of the following (please circle)?

Depression    Anxiety    Bipolar    Alcohol/Drug Addiction    ADHD    Schizophrenia

**15.** Please describe in your own words why you are currently seeking counseling:

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**16.** Family Background: Describe your past and current relationships with those who raised you and whom you grew up with?

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**17.** How many siblings do you have?

\_\_\_\_\_ Sisters      \_\_\_\_\_ Step-Sisters      \_\_\_\_\_ Half Sisters  
\_\_\_\_\_ Brothers      \_\_\_\_\_ Step-Brothers      \_\_\_\_\_ Half Brothers

**18.** Current Living Arrangements:      Own      Rent      Live with Family / Friend

**19.** Number of People in Household: \_\_\_\_\_

**20.** Name of Household Members/Relationship/Age:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_



**PLEASE LIST A PERSON TO CONTACT IN CASE OF AN EMERGENCY**

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Telephone: \_\_\_\_\_

Relationship of contact person to client: \_\_\_\_\_

**PHYSICIAN:** Please provide the name, address, and telephone number of your personal physician or clinic: (they will not be contacted without your permission)

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Telephone: \_\_\_\_\_

\_\_\_\_\_ I do not currently have a personal physician or clinic to take care of my general health problems.

**How would you describe your current physical health?**

Excellent                      Good                      Fair                      Poor



**PLEASE CIRCLE ALL THAT PERTAIN TO YOU**

- |                    |                      |                      |                      |
|--------------------|----------------------|----------------------|----------------------|
| STRESS             | EATING PATTERNS      | PURPOSE IN LIFE      | PARTNERSHIP/MARRIAGE |
| RELAXATION         | BINGEING             | FITTING IN           | BREAK-UP/DIVORCE     |
| NERVOUSNESS        | VOMITING             | FRIENDS              | PARENTING            |
| ANXIETY            | PURGING              | LONELINESS           | CHILDREN             |
| FEARS              | WEIGHT               | RELATIONSHIPS        | PARENTS              |
| CHEST PAINS        | DEPRESSION           | SHYNESS              | SEPARATION           |
| MUSCLE TENSION     | UNHAPPINESS          | PHYSICAL CONTACT     | GENDER ISSUES        |
| HEADACHES          | SLEEP PROBLEMS       | SHAME                | SEXUAL PROBLEMS      |
| DIZZINESS          | LOSS OF INTEREST     | ABUSE                | EDUCATION            |
| NERVOUS TICS       | WITHDRAWAL           | FLASHBACKS           | LEARNING DISABILITY  |
| PALPITATIONS       | APPETITE             | DISSOCIATION         | FINANCES             |
| EXCESSIVE SWEATING | SELF WORTH           | NIGHTMARES           | WORK                 |
| EXCESSIVE THIRST   | TIREDNESS            | HURTING SELF         | AMBITION             |
| PHOBIC AVOIDANCE   | BOREDOM              | RISK TAKING BEHAVIOR |                      |
| HYPOCHONDRIASIS    | MEMORY               | ATTENTION DEFICIT    | AVOIDANCE            |
| COMPULSIONS        | CONCENTRATION        | EXCITEMENT SEEKING   | LEGAL MATTERS        |
| RITUALS            | GUILT                | DRUG/ALCOHOL USE     | MY THOUGHTS          |
| BOWEL TROUBLE      | MAKING DECISIONS     | SELF-CONTROL         | MY BELIEFS           |
| STOMACH TROUBLE    | ENERGY               | ANGER                | FEELING UNREAL       |
| HEALTH PROBLEMS    | OVER FOCUSED         | AGGRESSIVE BEHAVIOR  | ODD BEHAVIOR         |
| PAIN               | INFERIORITY FEELINGS | TEMPER OUTBURSTS     | HALLUCINATIONS       |
| SUICIDAL THOUGHTS  |                      | JEALOUS FEELINGS     | HEARING THINGS       |
| SUICIDAL PLANS     |                      | LOSS OF CONTROL      | UNUSUAL EXPERIENCES  |
| SUICIDAL BEHAVIOR  |                      | SUSPICIOUS OF OTHERS | DELUSIONS            |