Client Legal Name - First, Last

Date of Birth

Client Address

Please complete the following form prior to your first session, as it will contain information that will be useful to your treatment.

If you ARE NOT the patient (for example if you are filling this out for a child or relative) please fill in the form about the patient to the best of your knowledge.

SYMPTOMS

Click the box beside each concern experienced recently

- [ ] Anxiety
- [ ] Thoughts of Suicide
- [ ] Anger Outbursts
- [ ] Memory Problems
- [ ] Treated Unfairly
- [ ] Concentration Problems
- [ ] Eating Disorder
- [ ] Drinking Problem
- [ ] Stress
- [ ] Feeling Confused
- [ ] Feeling Lonely
- [ ] Worry
- [ ] Specific Fear
- [ ] Poor Motivation
- [ ] Perfectionism
- [ ] Social Withdrawal
- [ ] Religious Concerns
- [ ] Hearing Strange Voices
- [ ] Mood Swings
- [ ] Depression
- [ ] Panic
- [ ] Changes in Weight
- [ ] Sexual Problems
- [ ] Frequent Pain
- [ ] Restlessness
- [ ] Legal Difficulties
- [ ] Boredom
- [ ] Shyness
- [ ] Guilt Feelings
- [ ] Thoughts of hurting others
- [ ] Money Problems
- [ ] Mourning
- [ ] Feeling Abandoned
- [ ] Unusually Sensitive
- [ ] Feeling Misunderstood
- [ ] Disappointment
- [ ] Feeling Inferior
- [ ] No problems or concerns
- [ ] Sleep Problem
- [ ] Unusual Thoughts
- [ ] Crying Spells
- [ ] Relationship Difficulties
- [ ] Low Energy
- [ ] Nausea
- [ ] Drug Use
- [ ] Hopelessness
- [ ] Work Problems
- [ ] Suspicion
- [ ] Compulsions
- [ ] Difficulty with Decisions
- [ ] Physical Illness
- [ ] Meaninglessness
- [ ] Irritability
- [ ] Troublesome Thoughts
- [ ] Impulsive
- [ ] Irrational Thoughts

Discuss any additional concerns or symptoms here:

What stresses/life changes have happened recently?

Past Treatment

Please list any current or past counselors/psychologists/psychiatrists who have treated you as well as any psychiatric hospitalizations or addiction treatment facilities you have experienced.

Year Seen	Problem Treated	Provider's Name / Hospital Name	Length of Treatment

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Your Family (as you experienced them growing up)

Mother	Mother's First Name	Any Personality/Mental Health Problems?
Father	Father's First Name	Any Personality/Mental Health Problems?
Choose Relationship	Their First Name	Any Personality/Mental Health Problems?
Choose Relationship	Their First Name	Any Personality/Mental Health Problems?
Choose Relationship	Their First Name	Any Personality/Mental Health Problems?
Choose Relationship	Their First Name	Any Personality/Mental Health Problems?
Choose Relationship	Their First Name	Any Personality/Mental Health Problems?
Choose Relationship	Their First Name	Any Personality/Mental Health Problems?
Choose Relationship	Their First Name	Any Personality/Mental Health Problems?

Choose Relationship	Their First Name	Any Personality/Mental Health Problems?

Add additional family info below:

My Childhood Experiences

Check any of the following boxes that applied to you as a child.

- ☐ Happy Childhood
- ☐ Neglected
- ☐ Family Moved Frequently
- ☐ Physically Abused
- ☐ Sexually Abused
- ☐ Few Friends
- ☐ Over/Under weight
- ☐ Popular
- ☐ Parents Divorced
- ☐ Family Fights
- ☐ Poor Grades
- ☐ Conflict with Teachers
- ☐ Drug or Alcohol Abuse
- ☐ Good Grades
- ☐ Sexual Problems
- ☐ Depressed
- ☐ Spoiled
- ☐ Anxious
- ☐ Not allowed to grow up
- ☐ Attention Problems
- ☐ Anger Problems

Discuss any additional childhood experiences here:

Members of Your Current Household

Relationship	First Name	Personality/Mental Health Issues
Relationship	First Name	Personality/Mental Health Issues
Relationship	First Name	Personality/Mental Health Issues
Relationship	First Name	Personality/Mental Health Issues
Relationship	First Name	Personality/Mental Health Issues
Relationship	First Name	Personality/Mental Health Issues

Relationship | First Name | Personality/Mental Health Issues

Relationship | First Name | Personality/Mental Health Issues

Add additional members / further describe below:

My Relationship History

How many times have you been married? | Age at first marriage:

Describe any typical problems experienced in past or current marriages or c0-habitation relationships:

Education / Occupation

Select All that apply:

- [ ] Currently Working Full Time
- [ ] Currently Working Part Time
- [ ] Currently Searching for Work
- [ ] Currently in School

Highest Level of Education So Far: | Favorite Subject in School

If currently working, how many hours per week? | In what field do you usually work?

Briefly describe your work/school likes/dislikes

Health

Primary Physician's Name and Phone Number:

Check all that you have ever experienced:

- [ ] Recent Surgery
- [ ] Thyroid Problems
- [ ] Chronic Pain
- [ ] Hormonal Problems
- [ ] Head Injury
- [ ] Drug/Alcohol Abuse Treatment
- [ ] Headaches
- [ ] Infertility
- [ ] Seizures
- [ ] Neurological Problems
- [ ] Diabetes
- [ ] Miscarriage

List any other chronic health problems:

How many hours of sleep in an average night?

How many alcoholic beverages consumed per week?

Tobacco Use Per Day:

Recreational drugs used in past year:

Type and Frequency of Physical Activity

Are you concerned about your physical health?

When was your last physical?

Please list your current medications in the blanks below. Include the Medication name, your understanding of why it's been prescribed, and how long you've taken it. For example: Zoloft, for depression, since April of 2021

Medication Name | Why Prescribed | It's been prescribed since.....(date or year)

Medication Name | Why Prescribed | It's been prescribed since.....(date or year)

Medication Name | Why Prescribed | It's been prescribed since.....(date or year)

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Medication Name	Why Prescribed	It's been prescribed since.....(date or year)

Accomplishments / Additional Information

Tell me about your personal strengths and important accomplishments:

Please add additional information that it might be important for your therapist to know:

Please type in the name of the person who filled out this form in the line below. If you are not the patient, please also indicate your relationship to the patient.

Enter Name Here:

New Signature Field

Erase Type

New Date Field

Harmony In Hues Wellness Center