Demographic Information

Name: ____ Date: ________________________

DOB: ___________________ Age: ________ Gender:_______________ Military service: ______________

Birthplace: ___________________________________ Race/Ethnicity: ____________________________

Growing up my family financial situation was: ____________________ Now it's: _____________________

Street Address: ____

City: ______________________________ State: ______ Zip Code: ____________________

Is it ok to send something in the mail? YES NO

Phone Number(s): ____

Is it ok to leave a voicemail? YES NO Appointment reminder text? YES NO

Email: ____

Is it OK to send email? YES NO

How were you introduced to us? ____

If you found us online what words did you search to find us? ______________________________________

** Please complete below for additional client **

Name: ____ Relationship to first client: __________________

DOB: ___________________ Age: ________ Gender: _______________ Military service: ______________

Birthplace: ___________________________________ Race/Ethnicity: ______________________

Growing up my family financial situation was: ___________________ Now it's: ______________________

Street Address: ____

City: ______________________________ State: ______ Zip Code: ____________________

Is it ok to send something in the mail? YES NO

Phone Number(s): ____

Is it ok to leave a voicemail? YES NO Appointment reminder text? YES NO

Email: ____

Is it OK to send email? YES NO

What issues brought you here?

(use back or extra paper if needed)

What are the 3 biggest concerns you have right now? How long have each been going on? Put them in order of importance:

1. ______________________________
2. ______________________________
3. ______________________________

What do you think those that care about you would say are their concern(s) regards to you?

____
____
____

What solutions (helpful or unhelpful) have you tried to resolve the above concerns?

____
____
____

Have you had therapy in the past? If so, with whom and when? What reasons did you attend therapy for? Please share about your experience. Helpful? Unhelpful?

____
____
____

Are you currently in Therapy? ______ If yes, with whom: ______________________________
Contact information: ______________________________
What services do they provide: ______________________ Will you allow consultation: YES NO

Change is Coming…

What are your expectations from therapy? What are your expectations of the therapist?

____
____

Looking into the future, how will you know that our work and time together has been worth it? List concrete changes you will see:

____
____

What other things would you like to see change in your life (family, career, health, relationships, etc.)?

____
____

Do you foresee any obstacles to achieving your goals or the desired changes?

____

____

How long do you think therapy will need to last to achieve your goals? Write down a target date:

____

List 5 strengths about yourself or that others say about you, give examples of each:

1. ____
2. ____
3. ____
4. ____
5. ____

Is there anyone that you would like to be a part of your sessions or think may be helpful to be part of sessions either now or in the future? ____

Medical & Wellness Information

What do you do for wellness (i.e. healthy food choices, exercise, limits on TV/electronics/work, managing stress, family time, leisure, etc.)? Give examples of each:

____

____

How do you achieve balance in your life?

____

____

Have you ever received psychiatric services? YES NO

If yes, how long ago, with whom, for what, medications prescribed and results:

____

____

Do you have any allergies (food, environmental, medicinal, animal, etc.)?

____

Do you have any current or past medical issues, hospitalizations, accidents, injuries or surgeries? If yes, what?

____

____

Is there a family history of the above medical issues/concerns?

____

____

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(512)710-7388
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Are you presently under a physician's/psychiatrist's care? If so, for what reason?

____

____

Is there anyone in your life that is currently dealing with a medical issue that you are concerned about? If so, whom, for what?

____

____

Recently, have there been any changes in your life? (i.e.: moves, appetite, sleep, health, family, overall functioning)?

____

____

List any medications (over-the -counter & prescribed), nutritional or herbal supplements, or alternative treatments (acupuncture, chiropractic, etc.) you are taking/doing and the reasons:

____

____

Important Questions We Must Ask

Have you ever had, or are you currently experiencing suicidal ideation? YES NO
If yes, please explain:

____

____

Have you ever planned to hurt yourself? YES NO
If yes, please explain:

____

____

Have you ever attempted to hurt yourself? YES NO
If yes, please explain:

____

____

Have you ever felt like you wanted to seriously hurt or harm someone else? YES NO
If yes, please explain:

____

____

Do you have weapons in your home or access to weapons? YES NO

If yes, who has access to them and what are the safety protocols around them?

____

____

Is there any history past or present of abuse or violence? YES NO
If so, please explain:

____

____

Are you currently using any illegal drugs, alcohol, or prescription medications in a way other than was prescribed, or is the reason you are seeking therapy services substance related? YES NO

____

____

Have you ever witnessed or experienced a trauma? Do you have reoccurring nightmares, flashbacks, or do you avoid anything that is uncomfortable or painful? YES NO
If so, please explain:

____

____

____

Are there currently legal issues or is therapy related to a court order? YES NO
If so, please explain?

____

____

Career/Job, Recreation and Leisure

What is your highest level of education completed and field of study?

____

What is your current occupation? How would you describe your job/career satisfaction or enjoyment?

____

____

____

____

What do you enjoy doing during your free/leisure time?

____

____

____

____

Gender Identity

How do you identify your gender? ____

Is this the gender identity you were assigned at birth? YES NO

How comfortable are you in your gender identity? ____

____

Intimate Relationships

Describe your sexual orientation: ____

How comfortable are you with your sexual orientation? ____

If you are currently in a relationship, describe your relationship:

____

____

How would you describe your communication in your relationship?

____

____

How would you describe intimacy in your relationship?

____

____

* If you are in a relationship answer the following regarding your relationship:

1. Like ____
2. Dislike ____
3. Not enough of ____
4. Too much of ____
5. Ideal relationship ____

Understanding Your Family & Influences

Parent's marital status: ____

Unique parental relationship factors (adoption, deceased, raised by relatives, etc.):

____

____

Please describe your relationship with your parents:

____

____

How would you describe your upbringing?

____

____

Who lives with you currently?

____

____

Do you have any pets? If yes, names, types and relationship to each pet:

____

____

Describe your relationship with the following: (If father or mother is inaccurate for you, adjust as necessary)

Mother:

____

Father:

____

Mother's Significant Other:

____

Father's Significant Other:

____

Siblings: (Name, Gender and Age: Relationship)

a. Sibling 1: ____
b. Sibling 2: ____
c. Sibling 3: ____

Children: (Name, Gender and Age: Relationship)

a. Child 1: ____
b. Child 2: ____
c. Child 3: ____

Significant Other/Spouse (name and relevant information): ______________________________

____

Is there a significant X that is a factor in your life? YES Name: ______________________ NO
If yes, Explain: ______________________________

____

Relationships

Describe your relationship with your friends:

____

____

Who would you say your support system is (people, organizations, or affiliations)?

____

____

Do you belong to any religious or spiritual groups? YES: ______________________ NO
If yes, what is your level of involvement?

____

How do your religious or spiritual beliefs/practices influence your life?

____

____

Do you see your faith/spirituality as an important part of your therapeutic growth/healing process? YES NO

Additional Information

Please list anything else that is important for me to know about you that would assist me in working with you to achieve your desired results:

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____

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____

____

____

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