Please fill in the information below and bring it with you to your first session. Please note: information provided on this form is protected as confidential information.

Personal Information:

Name:_____ Date: _____
Parent/Legal Guardian (if under 18): _____
Address: _____
Home Phone: ___ _____ May I leave a message? □ Yes □ No Cell/Work/
Other Phone: _____ May I leave a message? □ Yes □ No
Email: _____ May I contact you by email? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

DOB: _____ Age: _____ Gender: _____

Gender Pronouns:_____ Sexual Orientation:_____

Martial Status: □ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Children/ Ages_____

With whom do you live? Spouse_____ Parents _____ Other_____

List 2 people to be contacted in case of emergency:

Name/Relationship: _____

Name Relationship: _____

Do you have any pets? _____

Driver's License_____ Occupation _____

Approximate Yearly Income _____

Education (List Degrees) _____

Referred by _____ Permission to acknowledge? _____

Health History:

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes, previous therapist/practitioner: _____

Length of therapy? _____

Current Physician's Name/Phone Number _____

Are you currently taking any prescription medication? □ Yes □ No If yes, please list:
_____
_____

Have you ever been prescribed psychiatric medication? □ Yes □ No If yes, please list and provide dates:
_____
_____

Current Psychiatrist's Name /Phone Number (If applicable)
_____

Have you ever been hospitalized for psychological reasons or drug dependency?

□ Yes □ No If yes, please describe: _____

General and Mental Health Information:

How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing: _____
_____

How would you rate your current sleeping habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:
_____
_____

How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

Please list any difficulties you experience now or in the past with your appetite or eating problems:
_____

Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long?_____

Are you currently experiencing any thoughts of self harm or suicide? □ No □ Yes

If yes, please describe _____

Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? _____

Are you currently experiencing any chronic pain? □ No □ Yes If yes, please describe:
_____

Do you have a history of recreational drug use? □ No □ Yes

If yes, please describe _____

Do you drink alcohol more than once a week? □ No □ Yes

If yes, how often _____

How often do you engage in recreational drug use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?
_____

On a scale of On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your sexual satisfaction?
_____

Family History & Childhood Experience:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

Please Circle and List Family Member:

Alcohol/Substance Abuse yes / no _____

Anxiety yes / no _____

Depression yes / no _____

Domestic Violence yes / no _____

Eating Disorders yes / no _____

Obesity yes / no _____

Obsessive Compulsive Behavior yes / no _____

Schizophrenia yes / no _____

Suicide Attempts yes / no _____

Parents: *Name, age; if deceased, year and cause of death, occupation, personality. Brief statement about the relationship.*

Father: _____

_____

_____

Mother: _____

_____

_____

Step-parents and/or birth parents: _____

_____

_____

Siblings: *Name and age; if deceased, age and cause of death. Brief statement about the relationship*

_____

_____

Family medical history: *Describe any medical illness that runs in the family.*

_____

_____

Describe your childhood in general: *Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral problems, abusive/alcoholic parents.*

_____

_____

_____

_____

_____

If parents divorced, your age at the time: _____. *Describe how it affected you at the time.*

_____

_____

Past partnerships/marriages: *Years together, names & statement about the nature of the relationship.*

_____

_____

Children: *Include step-, grand-, adopted and children by birth. Names, ages & brief statement on your relationship. If adopted, at what age was child placed? Domestic or foreign adoption? Open or closed adoption?*

_____

_____

_____

_____

Trauma History:

Have you ever experienced any of the following events? If yes please indicate your age at the time of the event, and any other details you wish to provide. Please feel free to use back of paper if needed. Indicate N/A next to each item that does not apply to you in any way.

Childhood neglect:

_____

_____

Being bullied:

_____

_____

Childhood physical abuse:

_____

_____

Natural disaster:

_____

_____

Childhood sexual abuse:

_____

_____

Death of a loved one:

_____

_____

Childhood loss of a parent either by death or divorce:

_____

_____

Witnessed another's suicide or murder:

_____

_____

Rape/sexual assault:

_____

_____

Experienced a suicide attempt:

_____

_____

Physical assault:
_____
_____

Military combat:
_____
_____

Domestic violence:
_____
_____

Have/or have had a life -threatening illness:
_____
_____

Community violence:
_____
_____

Transportation accident:
_____
_____

Additional Information:

Are you currently employed? □ No □ Yes If yes, what is your current work situation?
_____

Do you enjoy your work? Is there anything stressful about your current work?
_____
_____

Describe the quality of your relationships with your friends and community: *Describe quality, frequency of contact, activities*.

_____
_____
_____

Do you consider yourself to be spiritual or religious? □ No □ Yes If yes, describe your faith or belief:
_____

JULIA BARRY
PSYCHOTHERAPY

Presenting problem: *Please be as specific as you can. What brings you to therapy?*

When did it start? How does it affect you? Who is involved?

_____

_____

_____

How severe is the problem? mild ___ moderate ___ severe ___ very severe ___

What significant life changes or stressful events have you experienced recently? _____

_____

_____

Resources: things, places relationships or activities that

1. *calm you down* _____
2. *engage you* _____
3. *bring you pleasure* _____
4. *help you sleep* _____

When you have a good day, what makes it better than other days? _____

_____

Who in your life have you felt closest to and why?

_____

_____

Who or what do you rely on for strength and support?

_____

_____

In what environments do you feel the safest/ most comfortable (nature, etc.)

_____
_____

What do you consider to be some of your strengths?
_____
_____

What do you consider to be some of your greatest areas of challenge?
_____
_____

What would you like to accomplish out of your time in therapy?
_____
_____
_____

What gives you the most pleasure or joy in your life? _____
_____
_____

What do you do to relax, have fun, take care of yourself? _____
_____
_____

What are your main worries and fears? _____
_____
_____

What are your most important hopes or dreams? _____
_____

_____

Please add on a separate page any other information you would like me to know about you and your situation.