General Name:

Street address:

City: State:

Cell phone:

Email:

Date of Birth:

Employment/Unemployed/Student:

Method of Payment: Out of pocket \_\_\_\_\_\_\_\_\_\_ EAP\_\_\_\_\_\_\_\_\_\_

Services What type of services are you seeking: \_\_ individual \_\_couples

Issues What concern or issue would you like to address?

**Mental Health History**

Have you ever participated in therapy: Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, was it a positive/neutral/poor experience?

Have you ever been hospitalized for mental health issues: Yes\_\_\_ No\_\_

Medication and Supplements

Have you or are you currently taking any prescription medication for mental health: Yes\_\_\_\_\_ No\_\_\_\_\_

If so, please provide permission and name of prescribing doctor. Initial here for permission:

Contact info:

 Do you use any other substances or over the counter supplements for mental health/well being?

**Current Mental Health**

Have you experienced any of the following (indicate past or current):

\_\_\_\_Thoughts of self harm (past\_\_\_\_ or present \_\_\_\_) \_\_\_\_Suicidal thoughts (past\_\_\_\_ or present\_\_\_\_\_) \_\_\_\_Thoughts of harm to others (past \_\_\_\_ or present\_\_\_\_\_)

**Emergency contact info**

Name & Phone:

Please write here anything else you think I should know:

Good for you that you are taking steps towards your better well being! I look forward to talking to you!

Thank you!!