Today's Date: _____

Your Full Name: _____

Street Address: _____

City, State, & Zip Code: _____

Telephone: Home: _____ Cell: _____

Date of Birth: _____ Gender: _____

Emergency Contact

Name: _____

Relationship to Client: _____ Phone: _____

Work/Education: Employer or School Name:

_____

Occupation: _____

Language: _____ Ethnicity: _____

Household: Marital Status: _____Family Size: _____ (Including Client)

Why you are seeking counseling?

_____

_____

_____

Have you ever seen a therapist before? Yes ____No___

If yes, when and for how long? _____

Have you recently experienced any of the following? 0 – none 1 – mild 2 – moderate 3 - severe				
	0	1	2	3
Memory Problems				
Anxiety				
Depression				
Suicidal thoughts				
Homicidal thoughts/ intent to harm				
Anger				
Fear				
Unwanted thoughts				
Worrying				
Change in weight				
Eating difficulties				
Sleep difficulties				
Difficulty concentrating				
Racing thoughts				
Low energy				
Other				

Have you or a family member experienced any of the following? Please check those that apply.		
	Self	Family Member
Alcoholism		
Drug addiction		
Mental illness		
Suicide (or attempts)		
Hospitalization for mental health		
Hospitalization for physical illness		
Physical abuse		
Sexual abuse		
Recent death of someone close		
Domestic violence		
Physical pain		
Combat		
Military Service		
Other:		

How would you rate the overall severity of these symptoms? (circle one)

1 2 3 4 5 6 7 8 9 10

Mild Moderate Severe

How would you rate your overall functioning? (circle one)

1 2 3 4 5 6 7 8 9 10

Unable to function in all areas — Unable to function in most areas — Serious difficulty — Moderate difficulty — Minimal difficulty — No Difficulty

Current medical/physical conditions, including allergies:

_____

Symptoms are Same____Better____Worse____

When did they change? _____

Are you receiving medical treatment for your condition or symptoms? Yes___No___

By whom: _____

Date of latest medical exam:_____ With Whom:_____

Reason: _____

Hospitalization in the last 12 months? Yes___No___

Reason:_____

Please list any prescription or non-prescription medications you are presently taking:

Medication	Dosage	What for?	Prescriber

Amount of coffee, tea, or soda pop you drink each day: _____

Do you use:

	Yes	No	How Often?	Amount (number of cigarettes, drinks, grams, etc.)	Have you ever been treated for addiction?
Any tobacco product?					
Alcohol?					
Any drugs? Types:					

Has your alcohol or drug use changed recently? Yes ___No___ If yes, in what way?

_____

Have you ever been treated for alcohol or drug addiction? Yes ___No___ If yes, when?

_____

Type of Treatment (inpatient, outpatient, AA, etc.):

_____

Is there anything else you'd like your therapist to know?

_____

_____

_____

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐