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Adult Therapy Enrollment Form

Please provide the following information for my records. Leave blank any questions you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session.

Name: Last: ____________________ First: ____________________ Middle: ______________________

Today's Date ___________________

Date of Birth: ___________________ Age: ____________________ Male ☐ Female☐ Transgender☐

Local Address: ____

City: ___________________________ State: ____________________ Zip: _______________________

Home Phone: ____________________ May I leave a message? Yes ☐ No ☐

Cell Phone: ____________________ May I leave a message? Yes ☐ No ☐

Email: ____________________ May I email you if needed? Yes ☐ No ☐

* *Please be aware that email might not be confidential.*

Person to contact in case of an emergency:

Name: ____________________ Relationship: ____________________ Phone: __________________

Primary Care doctor: Name: ___________________________________ Phone: __________________

What prompted you to seek therapy or an assessment? _____________________________________

____

Marital status: Never married ☐ Partnered ☐ Married☐
Separated ☐ Divorced ☐ Widowed ☐

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

If yes, for how long? ____________________

If yes, on a scale of 1-10 (10 = great), how would you rate the quality of your romantic relationship? ____________________

Do you have children? Yes ☐ No ☐

If yes, how many? ____________________ Ages? ____________________

Have you had previous psychotherapy? Yes ☐ No ☐

If yes, what led you to seek services? ______________________________

____

If yes, when? ______________________________

____

Are you currently taking prescribed psychiatric medication (antidepressants or others)? Yes ☐ No ☐

If yes, please list names and doses: ______________________________

____

If no, have you been previously prescribed psychiatric medication? Yes ☐ No ☐

If yes, please list names and dates: ______________________________

Are you hopeful about your future? Yes ☐ No ☐

Health Information

How if your physical health currently? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Date of last physical examination: ______________________________

Please list any chronic health problems or concerns (e.g. asthma, hypertension, diabetes, headaches, stomach pain, seizures, etc.): ______________________________

____

Any allergies? Yes ☐ No ☐ If yes, please list: ______________________________

Medications: ______________________________

Hours per night you normally sleep: ______________________________

Are you having any problems with your sleep habits? Yes ☐ No ☐

If yes, check where applicable:

Sleeping too little ☐ Sleeping too much ☐ Can't fall asleep ☐ Can't stay asleep ☐

Do you exercise regularly? Yes ☐ No ☐

If yes, how many times per week do you exercise? ____________ For how long? ____________

If yes, what do you do? ______________________________

Are you having any difficulty with appetite or eating habits? Yes ☐ No ☐

If yes, check where applicable: Eating less ☐ Eating more ☐ Bingeing ☐ Purging ☐

Have you experience significant weight change in the last 2 months? Yes ☐ No ☐

Do you regularly use alcohol? Yes ☐ No ☐

If yes, what is your frequency?

Once a month ☐ Once a week ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never ☐

How often do you engage in recreational drug use? Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never ☐

If checked any box other than "never", which drugs do you use? ______________________

Do you smoke? Yes ☐ No ☐ If yes, how many cigarettes per day? ______________________

Do you drink caffeinated drinks? Yes ☐ No ☐ If yes, # of sodas per day _____ cups of coffee per day______

Nutrition

Please describe your typical daily diet including timing of meals/snacks:

Breakfast: ______________________

Lunch: ______________________

Dinner: ______________________

Snacks: ______________________

Liquids: ______________________

Have you ever had a head injury? Yes ☐ No ☐

If yes, when and what happened?

____

In the last year, have you experienced any significant life changes or stressors? (For example: moving, job change, relationship difficulties, etc.) ______________________

____

Note: use the rating scale with a "yes" response only.

Are you **now experiencing**:			*Rating Scale 1-10 (10=worst)
Depressed mood or sadness	Yes	No	________
Irritability/Anger	Yes	No	________
Mood Swings	Yes	No	________
Rapid Speech	Yes	No	________
Racing Thoughts	Yes	No	________
Anxiety	Yes	No	________
Constant Worry	Yes	No	________
Panic Attacks	Yes	No	________
Phobias	Yes	No	________
Sleep Disturbances	Yes	No	________
Hallucinations	Yes	No	________
Paranoia	Yes	No	________
Poor Concentration	Yes	No	________
Alcohol/Substance Abuse	Yes	No	________
Frequent Body Complaints (e.g., headaches)	Yes	No	________
Eating Disorder	Yes	No	________
Body Image Problems	Yes	No	________
Repetitive Thoughts (e.g., obsessions)	Yes	No	________
Repetitive Behavior (e.g., counting)	Yes	No	________
Poor Impulse Control (e.g., spending)	Yes	No	________

Self-Mutilation	Yes	No	______________________
Sexual Abuse	Yes	No	______________________
Physical Abuse	Yes	No	______________________
Emotional Abuse	Yes	No	______________________

Have you experienced **in the past:**			*Rating Scale 1-10 (10=worst)
Depressed mood or sadness	Yes	No	______________________
Irritability/Anger	Yes	No	______________________
Mood Swings	Yes	No	______________________
Rapid Speech	Yes	No	______________________
Racing Thoughts	Yes	No	______________________
Anxiety	Yes	No	______________________
Constant Worry	Yes	No	______________________
Panic Attacks	Yes	No	______________________
Phobias	Yes	No	______________________
Sleep Disturbances	Yes	No	______________________
Hallucinations	Yes	No	______________________
Paranoia	Yes	No	______________________
Poor Concentration	Yes	No	______________________
Alcohol/Substance Abuse	Yes	No	______________________
Frequent Body Complaints (e.g., headaches)	Yes	No	______________________
Eating Disorder	Yes	No	______________________
Body Image Problems	Yes	No	______________________
Repetitive Thoughts (e.g., obsessions)	Yes	No	______________________
Repetitive Behavior (e.g., counting)	Yes	No	______________________
Poor Impulse Control (e.g., spending)	Yes	No	______________________
Self-Mutilation	Yes	No	______________________
Sexual Abuse	Yes	No	______________________
Physical Abuse	Yes	No	______________________
Emotional Abuse	Yes	No	______________________

Occupational, Educational and Legal Information:

Are you employed? Yes ☐ No ☐
If yes, who is your current employer/position? ______________________
If yes, are you happy at your current position? ______________________
Please list any work-related stressors, if any: ______________________
Do you have financial concerns? Yes ☐ No ☐
If yes, please explain: ______________________
Are you currently in the military? Yes ☐ No ☐ Previously? Yes ☐ No ☐
Highest level of education:
____
Do you have any legal concerns? Yes ☐ No ☐
If yes, please explain: ______________________

Family History:

Are your parents: Still together ☐
Divorced ☐ When? ____________
Remarried ☐
Unmarried ☐
Deceased ☐ If yes, whom ____________ Age at death ____________

Number of siblings: ____________ Ages: ____________

Do you have healthy family support? Yes ☐ No ☐ From whom? ________________

Family Mental Health History:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty:			Family Member(s):
Depression	Yes	No	________________
Bipolar Disorder	Yes	No	________________
Anxiety Disorders	Yes	No	________________
Panic Attacks	Yes	No	________________
Schizophrenia	Yes	No	________________
Alcohol/Substance Abuse	Yes	No	________________
Eating Disorders	Yes	No	________________
Learning Disabilities	Yes	No	________________
Trauma History	Yes	No	________________
Suicide Attempts	Yes	No	________________
Psychiatric Hospitalizations	Yes	No	________________

Other Information:

What role, if any, do religion and/or spirituality play in your life? ________________

____

____

____

Are you satisfied with your social situation/interpersonal relationships? Yes ☐ No ☐

If no, explain why: ________________

____

____

What do you consider to be your strengths? ________________

____

____

What are effective coping strategies you use when stressed?

____

____

____

What are your overall goals for therapy? ________________

____

What do you feel you need to work on first? ______________________________

How will you know that you are making progress? ______________________________

Is there anything that I did not ask about here that would be important for me to know about you?

Thank you. Please bring this completed form to your assessment appointment.