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Psychotherapy & Evaluation Services
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Name: ____ **Age**_____ **Date of birth:**______________________

Address: ____

City, State, Zip: ____

Phone (mark if ok to leave message): □ **Home:** (____) ________________ □ **Cell:** (____) ________________

Can I contact you by email? □ **No** □ **Yes** **Email address:** ____

Occupation: ______________________________________ **Highest level of education:** ______________________

Referred by: _________________________________

Please describe your goals for therapy:

____

____

____

____

History of Mental Health Diagnosis: ____

Current and/or Prior Behavioral Healthcare Services: Yes ☐ No ☐

Provider/Facility & Location	Dates (start-end)	Type of service	Reason for Tx & Dx	Tx Completed
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐

Has anything helped alleviate your distress? ____

Have you ever cut or injured yourself purposefully? Yes ☐ No ☐
If yes, please describe (when, how, outcome):

Please list:

Current Medical Conditions: ____

Past Medical Conditions: ____

Current Medications: ____

Current Physical Complaints: ____

Psychiatrist: ______________________________ **Ph:** ____________________ **Fax:** ______________

Sleep: ☐ no issues ☐ problems falling asleep ☐ frequent waking ☐ difficulty falling back asleep
☐ racing thoughts at bedtime ☐ drug dreams ☐ night terrors

Hr(s) per night: ________

Eating: ☐ binging ☐ purging ☐ unintentional weight gain ☐ unintentional weight loss ☐ no issues

Please describe your family of origin *(significant caretakers and siblings)***:**

____

____

____

____

Who currently resides in your home with you?

____

____

____

Who do you consider to be part of your support system? Please describe each person's relationship to you:

____

____

____

Legal History: ____

Please indicate current or prior involvement with any of the programs outlined below:

Probation ☐ Diversion ☐ Drug Court ☐ DCF ☐ PRN/IPN ☐

Probation Officer/Caseworker/Attorney (if applicable):________________________________