YOUR STORY COUNSELING

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Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. Please fill out this form and bring it to your first session if possible

_____

(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____

Gender: □ Male □ Female Marital Status: □ Never Married □ Domestic Partnership □ Married

□ Separated □ Divorced □ Widowed Please list any children/age:

_____
_____
_____

_
Current Address

_____

(City) (State) (Zip)

Home Phone:( )(-) May we leave a message? □ Yes □ No

Cell/Other Phone: ( )

May we leave a message? □ Yes □ No E-mail:

_____
_____
_____

May I email you? □ Yes □ No *Please note: Email correspondence is not considered to be a confidential medium of communication. Referred by (if any):

_____

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

_____
_____

Are you currently taking any prescription medication? □ Yes □ No Please list:

_____
_____

Have you ever been prescribed psychiatric medication?

□ Yes □ No Please list and provide dates

_____
_____
_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very Good Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____ What types of exercise to you participate in?_____

4. Please list any difficulties you experience with your appetite or eating patterns:

_____
_

5. Are you currently experiencing overwhelming sadness, grief, or depression? □ No □ Yes If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias? □ No □ Yes If yes, when did you begin experiencing this? _____

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

_____

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

9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes If yes, for how long? _____ On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY

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 (father, grandmother, uncle, etc.). Please Circle List Family Member

Alcohol/Substance Abuse yes/no

_____

Grandfather Grandmother, Father, Mother, Uncle, Aunt, Brother, Sister,\etc.

Anxiety yes/no

_____

Grandfather Grandmother, Father, Mother, Uncle, Aunt, Brother, Sister,\etc

Depression yes/no

_____

Grandfather Grandmother, Father, Mother, Uncle, Aunt, Brother, Sister,\etc

Domestic Violence yes/no

_____

Grandfather Grandmother, Father, Mother, Uncle, Aunt, Brother, Sister,\etc

Eating Disorders yes/no

_____

Grandfather Grandmother, Father, Mother, Uncle, Aunt, Brother, Sister,\etc

Obesity yes/no

_____

Grandfather Grandmother, Father, Mother, Uncle, Aunt, Brother, Sister,\etc

Obsessive Compulsive Behavior yes/no

_____

Grandfather Grandmother, Father, Mother, Uncle, Aunt, Brother, Sister,\etc

Schizophrenia yes/no

Grandfather Grandmother, Father, Mother, Uncle, Aunt, Brother, Sister,\etc

Suicide Attempts yes/no

Grandfather Grandmother, Father, Mother, Uncle, Aunt, Brother, Sister,\etc

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes If yes, what is your current employment situation?

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

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

3. What do you consider to be some of your strengths?

4. What do you consider to be some of your weaknesses?

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

Insurance Information

Company Name (United, BCBS etc.)

_____

Insured Name and Relation

_____

Policy Number

_____

Group Number

_____

Effective Date _____

Client _____ Date (_____)

Jeffrey Meuser _____ Date (_____)