

Guardian/Parents: (if under 18) _____

Have you had previous therapy? Yes No Spiritual or Pastoral Counseling? Yes No

When _____ With whom? _____

Are you presently seeing another therapist? Yes No

Your Physician's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: _____

When was your last medical exam? _____

Are you currently on medication? Yes No

If so, what medication? _____

Prescribed by: _____

Major surgeries or illnesses in past five years? Yes No

For what condition(s): _____

Other health related conditions: _____

What do you believe your physical condition is at the present time? (Check one) Poor Fair Average Good Excellent

What do you believe your emotional condition is at the present time? (Check one) Poor Fair Average Good Excellent

Which of the following describe or relate to the concerns which bring you here:

- | | | | |
|--|---|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Aging issues | <input type="checkbox"/> Suicidal feelings | Relationship with: | Loss of: |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Religious doubts | <input type="checkbox"/> Partner | <input type="checkbox"/> Self respect |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Legal Issues | <input type="checkbox"/> Parents | <input type="checkbox"/> Faith |
| <input type="checkbox"/> Frequent crying | <input type="checkbox"/> Finances | <input type="checkbox"/> Children | <input type="checkbox"/> Meaning |
| <input type="checkbox"/> Eating/Food | <input type="checkbox"/> Vocation/Career issues | <input type="checkbox"/> Others | <input type="checkbox"/> Love |
| <input type="checkbox"/> Alcohol/Drugs | <input type="checkbox"/> Physical health | | Abuse Issues: |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Self esteem | | <input type="checkbox"/> Physical |
| <input type="checkbox"/> Self doubt | <input type="checkbox"/> Poor appetite | | <input type="checkbox"/> Sexual |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Sleep disturbance | | <input type="checkbox"/> Emotional |
| <input type="checkbox"/> Sexual concerns | <input type="checkbox"/> Hopelessness | | |
| <input type="checkbox"/> Fear | <input type="checkbox"/> Weight Loss | | |
| <input type="checkbox"/> Grief | | | |
| <input type="checkbox"/> Mid-life issues | | | |

State in your own words the concerns that bring you to therapy: _____

What do you hope to achieve in therapy (your goals/expectations)? _____