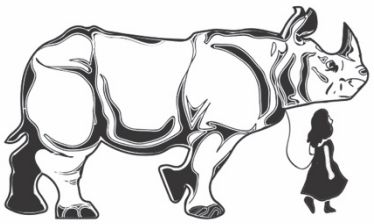

Tame Your Rhino

Counseling for Social/Emotional Resiliency

Carrie B. Evans, M.A., L.C.S.W
720-260-2901 • tameyourrhino.com

Personal Background Information

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.

Name: _____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: _____

Marital Status: □ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Please list any children/age: _____
Address: _____
(Street and Number)
_____
(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 and approximate 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:

Are you currently taking any prescription medication? □ No □ Yes; Please list below:
_____
What self-care behaviors do you engage in when life is challenging?_____
_____
Have you ever been prescribed psychiatric medication? □ No □ Yes Please list and provide dates:_____

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:

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3. How many times per week do you generally exercise? _____
In what types of exercise do you participate ?_____

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. How frequently do you drink alcohol? _____number of drinks per week

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 (low to high), 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.).

- ☐ Domestic Violence _____
- ☐ Eating Disorders _____
- ☐ Obesity _____
- ☐ Obsessive Compulsive Behavior _____
- ☐ Schizophrenia _____
- ☐ Suicide Attempts _____
- ☐ Learning disability_____
- ☐ Alcohol/Substance Abuse _____
- ☐ Anxiety _____
- ☐ Depression _____
- ☐ Attention Issues_____
- ☐ Social Communication difficulties_____

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 weakness?

_____

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

_____

_____

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