Confidential Information			
		Name: Today's Date: D.O.B:	
CONTACT INFORMATION Address:			
Day Phone: Cell Phone & or Evening Phone: Email:			
DEMOGRAPHIC INFORMATION Current Age:	Gender:	Eth	nicity/Culture:
Relational Status (please circle	one): Single	Married	Significant Partner
Occupation/School:			
Emergency Contact (Name and	d Relationship):		
Emergency Contact Phone number:			
CURRENT MEDICAL Do you have any Medical Cond	itions/Concerns (or Allergies:	
List any prescription medicatio	n you may be tal	king and the k	dosage:
List any Homeopathic or Nature	opathic medicati	on you are us	ing:
CURRENT SUBSTANCE USE Do you smoke or use tobacco p	products? YES No	O If yes, how	often:

Do you use any other Substances? (including pharmaceutical drugs that are not

prescribed to you) YES NO If yes, please list type and frequency:

Problematic Alcohol Use YES NO If yes, please list amount and frequency:

Do you have any legal concerns? YES NO if yes, please describe:

PAST/CURRENT MENTAL/EMOTIONAL HEALTH HISTORY

Have you ever been diagnosed by your primary care doctor or a mental health professional? YES NO If yes, please indicate diagnosis and approximate date

Have you had previous experience with therapy, counseling or psychiatric hospitalization? (Please circle all that apply) If circled, please indicate approximate dates:

Is there a history of mental illness in your family? YES NO UNCERTAIN If yes, please describe:

Have you experienced any of the following? (Please circle all that apply and briefly describe if able, include approximate date or age at which occured)

Physical Abuse Sexual Abuse Emotional Abuse/Neglect

Was this reported? YES NO To Whom:

Have you ever...(If Yes, please briefly describe)

Had any thoughts about hurting yourself or someone else? YES NO

Have you ever thoughts about suicide? YES NO

Have you ever attempted suicide? YES NO

Are you currently thinking about suicide YES NO If yes, do you have a plan? YES NO

Have you ever engaged in self-harm behaviors? YES NO

Are you currently engaging in any self-harming behaviors YES NO

Have you engaged in violent behavior towards others? YES NO What is the quality of your sleep? (Circle all that apply)

I sleep well and wake up rested. I have trouble falling asleep I have trouble staying asleep. I experience nightmares. I have strange or bizarre dreams. I don't really remember my dreams. I don't sleep enough. I sleep too much.

remember my dreams. I don't sleep enough. I sleep too much.
In the past month, more often than not, experienced any of the following (check all that apply)
angryanxiousabandondeddepresseddistracteddistantfairly positive about lifefearfulgriefguiltyhelplesshostilehyperactive have disturbing/unwelcome thoughtsimpulsiveirritatedlack of creativitylack of energylonelylovednervousnumbout-of-controlout-of-itpanickedparanoidreflectiverespectedrestlesssadself-criticalstucktensetroubledvigilantvulnerableworthless
Is there anything else you would like me to know about you and/or why you are entering counseling at this time?
SLIDING SCALE CONSIDERATIONS Sliding Scale is a range of fees I accept from my clients due to financial need and are not planning to be reimbursed by their insurance company (Though that does not disqualify you from sliding scale fees) If you feel that you can not reasonably afford the standard weekly fee, please fill out the following. The figures below are based upon the current availabilities on the sliding scale as of 7/25/16. Please refer to the Sliding Scale Policy or contact me for more information. Standard Session Fee is \$95.00 per session.
l have a financial need for reduced session fee
I think that I would be able to reasonably afford (check one please)
\$75-\$90 per session\$55-\$70 per session\$40.00-50.00 per session (weekly sessions only)