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Richmond, VA 23226
(804) 334-9169

Name: _____
(Last) (First) (Middle Initial)
SSN: _____
Birth Date: _____ /_____ /_____ Age: _____
Emergency Contact person & Phone:_____

Please describe your
Race & Ethnicity: _____

Gender: _____

Sexual Orientation: _____

Primary Relationship Status:
□ Single □ Partnered □ Married □ Separated □ Divorced □ Widowed
Any children? _____ If so, how many? _____

Local Address: _____
(Street and Number)

_____
(City) (State) (Zip) *Please list on the other side who you live with and your relationship.

Home Phone: ( ) _____ Message OK? □ Yes □ No

Cell/Other Phone: ( ) _____ Message OK? □ Yes □ No

E-mail: _____ May I email you? □ Yes □ No
*Please be aware that email might not be confidential.

Referred by: _____

Are you currently receiving psychiatric services, treatment for any mental health/substance abuse issue, professional counseling or psychotherapy elsewhere? □ Yes □ No
If yes, who? _____

Have you had previous psychotherapy?
□No □Yes, Previous therapist's name _____
Was it helpful? _____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
□Yes □No If Yes, please list with dosage: _____
Who prescribes this medication? _____

If no, have you been previously prescribed psychiatric medication?
□Yes □No If Yes, please list: _____

HEALTH AND SOCIAL INFORMATION
How is your physical health at present? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): _____

Please list any medications, supplements and/or vitamins you take: (include dosage)
_____

Are you having any problems with your sleep habits? □ No □ Yes
If yes, check where applicable:
□ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams
□ Other _____

How many times per week do you exercise? _____
Approximately how long each time? _____

Are you having any difficulty with appetite or eating habits? □ No □ Yes
If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting □ Purging
Have you experienced significant weight change in the last 2 months? □ No □ Yes

In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Rarely □ Never

Have you had suicidal thoughts recently? □ Frequently □ Sometimes □ Rarely □ Never
Have you had them in the past? □ Frequently □ Sometimes □ Rarely □ Never

Are you currently in a romantic relationship? □ No □ Yes
If yes, how long have you been in this relationship? _____
On a scale of 1-10, how would you rate the quality of your current relationship? _____

Have you ever had a head injury, such a concussion or TBI? _____

Do you, or anyone in your home/apartment own a gun? If yes, how is it kept?
_____

In the last year, have you experienced any significant life changes or stressors:

_____

OCCUPATIONAL INFORMATION:
Are you currently employed? □ No □ Yes
If yes, who is your current employer/position? _____

RELIGIOUS/SPIRITUAL INFORMATION:
Do you consider yourself to be religious? □ No □ Yes
If yes, what is your faith? _____
If no, do you consider yourself to be spiritual? □ No □ Yes

Briefly state why you are seeking help, and why now:

_____

_____

What efforts have you made to deal with these concerns?

_____

_____

_____

What are some of your desired outcomes for the therapy process?

_____

_____

_____