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General Information

Date: ______________________ Date of Birth: ______________________Age: ________________________

Full Name: ____

Address (include zip): ____

Phone: Home: _________________ Is it okay to leave a detailed message at this number? Yes __ No __

Cell: ___________________ Is it okay to leave a detailed message at this number? Yes __ No __

E-Mail Address: ____

Do I have your consent to email an appointment reminder prior to sessions? Yes _____ No _____

Do I have your consent to email digital copies of:

1) Records: Yes _____ No _____

2) Billing statements: Yes _____ No _____

Emergency contact name: ____

Phone #: ___________________________ Email Address: ____

Please tell me a little more about you:

Gender: ____

Ethnicity/Cultural identity: ____

Spiritual beliefs: ____

Disability (if any): ____

Sexual orientation: ____

Occupation and/or School & Major: ____

Handedness (right/left/ambidextrous): ____

Who referred you for counseling with me?____

Please briefly let me know what brought you:

____

____

____

How long have these problems occurred? (number of weeks, months, years)__________________________

Please list any other healthcare providers involved in your care (e.g., neurologists, other physicians, occupational therapists, etc.): ____

____

____

Developmental/Medical History

Medical History

Yes No Has your medical history been normal/unremarkable? If no, please explain: ________________
____
____

Yes No Have you received any medical diagnoses? Please explain: ________________________________
____
____

Yes No Have you completed genetic testing?
Yes No Have you had an MRI?
Yes No Have you had an EEG?
Yes No Frequent ear infections?
Yes No Were ear tubes ever placed?
Yes No Hearing problems?
Yes No Vision problems?
Yes No Headaches?
Yes No Meningitis?
Yes No Seizures?

Yes No Asthma?
Yes No Slow/fast growth?
Yes No Head injury?
Yes No Allergies?
Yes No Hospitalizations?
Yes No Have you experienced anything you would call traumatic (physical, verbal, or emotional abuse; unwanted sexual experiences; accidents or other events)?

Have you ever been hospitalized, had surgeries, or major illnesses?

Age	*How long*	*Reason*
________	______________	________________________________
________	______________	________________________________

What medications do you currently take? (Include over-the-counter supplements)

Name	*Dose*	*Frequency*	*Reason*
________	______________	______________	________________________
________	______________	______________	________________________

Describe your sleep routine:
Typical bed time: _____________ Typical wake time: ____________
Trouble falling asleep? **Yes No** Trouble staying asleep? **Yes No** Trouble waking up early? **Yes No**
Any other sleep problems? Explain: ____
____

Describe your diet: ____
____

Describe your current level and type(s) of exercise: __________________________________
____
____

Mental Health History

List any previous or current mental health diagnoses:____
____

Have you received therapy services or counseling in the past? **Yes** **No**
Name of provider:________________________________ Dates:__________________
Name of provider:________________________________ Dates:__________________
Name of provider:________________________________ Dates:__________________

Are you currently seeing a psychiatrist for medication? **Yes** **No** Have you in the past? **Yes** **No**
Name of Psychiatrist:______________________________ Dates of treatment:______________
Medication the Psychiatrist Prescribed:____

Is there a history of self-harm or suicidal thoughts, threats, or attempts? Please explain: ___________
____

Have you ever been hospitalized for mental health concerns? Please explain:____________________
____

Psychosocial Functioning

Describe your personality: ____
____
____

What are your non-academic strengths?
____

What are your non-academic weaknesses?
____

How do you spend your free time?
____
____

What is your current level of alcohol and/or drug use?
Alcohol: ____
Recreational drugs: ____

How is your social group? Do you have close friends? Any trouble initiating or maintaining relationships?
____
____
____
____

Please place a mark next to behaviors that you believe you experience to an *excessive or exaggerated degree* when compared to others your age.

Sleeping and Eating

- ❑ Nightmares
- ❑ Trouble falling asleep
- ❑ Trouble staying asleep in the morning
- ❑ Decreased need for sleep without getting tired
- ❑ Eats Poorly
- ❑ Eats excessively
- ❑ Excessive snoring during sleep

Social

- ❑ Prefers to be alone
- ❑ Excessively shy or timid
- ❑ More interested in objects than people
- ❑ Difficulty making friends
- ❑ Not sought out for friendship by peers
- ❑ Excessive daydreaming and fantasy life
- ❑ Difficulty seeing another person's point of view
- ❑ Trouble empathizing with others
- ❑ Overly trusting of others
- ❑ Trouble understanding/enjoying humor

Behavior

- ❑ Stubborn
- ❑ Irritable, angry, or resentful
- ❑ Strikes out at others
- ❑ Throws or destroys things
- ❑ Lying
- ❑ Stealing
- ❑ Argues with others
- ❑ Low frustration threshold
- ❑ Daredevil behavior
- ❑ Impulsive (does things without thinking)
- ❑ History of vocal or motor tics
- ❑ Poor sense of danger/risk
- ❑ Cries frequently
- ❑ Excessively worried and anxious
- ❑ Overly preoccupied with details
- ❑ Overly attached to certain objects
- ❑ Not affected by negative consequences
- ❑ Drug abuse
- ❑ Alcohol abuse

Motor Skills

- ❑ Poor fine motor coordination
- ❑ Poor gross motor coordination
- ❑ "Clumsy" in general

Legal History

Have you been involved with the court currently or in the past? ______________________________

Date(s): ______________________________

Describe: ______________________________

____

____

Family History

Are you (choose one): **Married** **Separated** **Divorced** **Living Together** **Single**

If married, for how long? ____

If separated or divorced, when? ______________________________________

Do you have children? Ages? ____

Who else lives in your home? ____

____

Have any of the following diseases occurred among your blood relatives (parents, aunts, uncles, grandparents)? Check those that apply:

- ❑ Allergies
- ❑ Amnesia
- ❑ Asthma
- ❑ ADHD
- ❑ Bleeding tendency
- ❑ Depression
- ❑ Cancer
- ❑ Suicide
- ❑ Learning problems
- ❑ Deafness
- ❑ Diabetes
- ❑ Glandular problems
- ❑ Heart diseases
- ❑ High blood pressure
- ❑ Kidney disease
- ❑ Alcohol/drug problem
- ❑ Anxiety
- ❑ Autism/Asperger's
- ❑ Intellectual disability/cognitive delay
- ❑ Seizures
- ❑ Cerebral Palsy
- ❑ Migraines
- ❑ Muscular Dystrophy
- ❑ Schizophrenia
- ❑ Other (specify): ____________________