Please list any medications, supplements or vitamins taken regularly:_____

_____

Please list the problems for which you are seeking counseling:

_____

_____

_____

Please rate the severity of your problem (or the problem your child is experiencing):

_____Mild _____Moderate _____Severe
_____Incapacitating

What do you hope to gain from therapy?

_____

_____

_____

Please list any counseling services received in the past:

_____

Please list any of your family members who have been treated for emotional difficulties:

_____

Have you or anyone in your family received inpatient psychiatric care? If yes, please list:

_____

Do you currently have thoughts of wanting to harm yourself or somebody else? (If you are a parent completing this for your child, please answer for your child.) If yes, please explain:

_____

In the last six months, have you used alcohol, marijuana or other mood altering substances?

_____

Have you ever been sexually assaulted, abused or harassed? (If you are a parent, please answer this for your child.) If yes, please explain:

_____