Susan Blank, LPC, NCC

Please fill out the following information. If there are any questions that you do not feel comfortable answering, please leave them blank, and we can discuss in session. All information will be held in strict confidentiality.

Today's Date: _____

Name: _____ Age: _____

Home Phone: _____ Mobile Phone: _____

Email: _____

Where may I leave a message?

_____

Address: _____

_____

Referred by: _____ May I thank them? _____ Yes _____ No

Relationship Status: _____

Partner's Name & Age: _____

No. of Children: _____ Names & Ages: _____

_____

Highest Level of Education: _____

Employer: _____

Please briefly explain why you are seeking therapy at this time.

_____

_____

_____

_____

How do these issues impact your social, professional and/or academic functioning? How long have you had these issues, and when did they first begin?

_____

_____

_____

What have you already done to try and manage these issues?

_____

_____

_____

Which of the following symptoms have you experienced? On a scale of 1–10, with 1 being extremely low and 10 being extremely high, please rate the severity of your symptoms.

- Significantly Depressed Mood: Now: ____ Past: _____ Severity: _____
- Feelings of hopelessness/helplessness: Now: _____ Past: _____ Severity: _____
- Change in appetite: Now: _____ Past: _____ Severity: _____
- Change in sleep patterns: Now: _____ Past: _____ Severity: _____
- Loss of energy: Now: _____ Past: _____ Severity: _____
- Poor concentration: Now: _____ Past: _____ Severity: _____
- Loss of interest in usual activities: Now: _____ Past: _____ Severity: _____
- Feelings of anxiety/worry/fear: Now: _____ Past: _____ Severity: _____
- Panic Attacks: Now: _____ Past: _____ Severity: _____
- Muscle tension/aches: Now: _____ Past: _____ Severity: _____
- Recurrent troubling thoughts: Now: _____ Past: _____ Severity: _____
- Thoughts of death or hurting yourself: Now: _____ Past _____ Severity: _____
- Difficulty controlling anger: Now: _____ Past: _____ Severity: _____
- Thoughts about hurting others: Now: _____ Past: _____ Severity: _____
- Other significant symptoms (please explain):

  _____

  _____

Which of the following stressors have you experienced? On a scale of 1–10, with 1 being extremely low and 10 being extremely high, please rate the severity of your stressors.

- Problem/Change in Couple Relationship: Now: _____ Past: _____ Severity: _____
- Disruption in other Family Relationships: Now: _____ Past: _____ Severity: _____
- Change in other Significant Relationships: Now: _____ Past: _____ Severity: _____
- Death of a loved one: Now: _____ Past: _____ Severity: _____
- Change in work status: Now: _____ Past: _____ Severity: _____
- Change in residence: Now: _____ Past: _____ Severity: _____
- Significant health problems: Now: _____ Past: _____ Severity: _____

- Change of life problems: Now: _____ Past: _____ Severity: _____
- Financial problems: Now: _____ Past: _____ Severity: _____
- Legal problems: Now: _____ Past: _____ Severity: _____
- Other significant changes or stressors (please explain):

  _____

  _____

Counseling History

Please list any prior counseling experience you have had: Year:_____ Length: _____

Reason for Treatment:

_____

Did you find counseling to be helpful? _____

If yes to the above, in what way?

_____

_____

Work/Vocational History

What is your current occupation? _____

Employer: _____

How long have you been employed in your present position? _____

Are you satisfied with your current job? _____ Yes _____ No

Since becoming an adult, how many different jobs have you held? _____

Have you had any periods of unemployment that lasted 4 months or longer? _____ Yes _____ No

If yes to the above, please describe circumstances briefly:

_____

_____

Have you made any career changes? _____ Yes _____ No

If yes to the above, what was/were your previous occupation(s)?

_____

_____

Any major changes in your current work situation during the past year? _____ Yes _____ No

If yes to the above, please describe:

_____

Medical History

Please list any medical conditions you have and the type of treatment you are receiving for each.

_____

_____

_____

_____

Please list all medications you are currently taking, including dosages if you know them:

MEDICATION	DOSAGE	PRESCRIBED BY

Previous Psychological/Psychiatric Treatment

Have you ever taken medications for psychological/psychiatric reasons? _____ Yes _____ No

If yes to the above, please indicate when and for what conditions/problems:

_____

_____

Have you ever been hospitalized for psychological/psychiatric reasons? _____ Yes _____ No

Has anyone in your family (parents, grandparents, siblings, children, other relatives) been diagnosed and/or treated for psychological/psychiatric condition(s)? _____ Yes _____ No

**If yes to the above, please explain:*

_____

_____

_____

Current and Past Use of Alcohol and Other Substances

If you currently drink alcohol, please describe the type of alcoholic beverages, the amounts, and the frequency:

_____

_____

If you currently drink alcohol, approximately how often do you have 4 or more drinks in one day?

_____

If you have used, or currently use, any recreational drugs, please describe which ones and your pattern(s) of use:

_____

_____

Have you ever tried to cut down on your use of alcohol and/or drugs? _____ Yes _____ No

Has anyone become angry with you because of your alcohol and/or drug use? _____ Yes _____ No

Have you ever felt guilty or worried about your use of alcohol and/or drugs? _____ Yes _____ No

Have you ever felt the need for an "eye-opener" in the morning? _____ Yes _____ No

Have you ever received outpatient treatment for substance use? _____ Yes _____ No

Have you ever received inpatient treatment or detox services for substance use? _____ Yes _____ No

Has anyone in your family had a problem with alcohol or drugs? _____ Yes _____ No

If yes, whom? _____

Please describe your past and current use of nicotine and/or caffeine:

_____

Legal Actions/Proceedings

Please check all legal actions and/or proceedings in which you have been involved:

Arrests/Assault	_____ Yes	_____ No
Arrests/Other	_____ Yes	_____ No
Restraining/Protective Order(s)	_____ Yes	_____ No
DUI	_____ Yes	_____ No

**If yes to the above, how many?* _____

Child Protective Services _____ Yes _____ No

Divorce/Custody _____ Yes _____ No

Disability Claims _____ Yes _____ No

Other (describe below):

_____

Personal Information

Place of birth: _____ Where were you raised? _____

Have you experienced a loss (death, divorce, or significant situational loss) in the past 24 months?

_____ Yes _____ No

Did you experience any losses as above during childhood or adolescence? _____ Yes _____ No

If yes, please indicate whom, and your age at the time of loss:

_____

Have you relocated or changed jobs within the past 24 months? _____ Yes _____ No

How many siblings do you have, and what is your birth order among them?

_____

Were you adopted or separated from your birth parents during childhood? _____ Yes _____ No

If yes, at what age? _____

Are your parents divorced? _____ Yes _____ No

If yes, please indicate your age at the time of their separation: _____

Please indicate your parents' current ages, or their ages at the time of their deaths:

_____

Mother's occupation(s)/highest level of education:

_____

Father's occupation(s)/highest level of education:

_____

Do you own or have access to firearms? _____ Yes _____ No

Has religion and/or spirituality played an important role in your life? _____ Yes _____ No

Has race, ethnicity and/or culture played an important role in your life? _____ Yes _____ No

Have you experienced physical, emotional and/or sexual trauma or abuse? _____ Yes _____ No

**If yes to the above, is this is something we can discuss in our sessions?* _____ Yes _____ No

Please use the space below to provide any additional information that you think would be important for me to know, including your goals for our work together.

_____

_____

_____

_____

_____

_____

_____

I give Mt. Vernon Counseling permission to discuss and/or receive treatment records from my past or current therapists, psychiatrists, and/or physicians, and/or to discuss my clinical information with my past and/or current therapists, psychiatrists and/or physicians.

Signature: _____ Date: _____

Thank you for taking the time to complete this questionnaire. I look forward to our journey together!

– Susan Blank, LPC, NCC