**PLEASE PRINT CLEARLY**

Name (first, middle initial, last):

DOB (mo/day/year):

Address:

Phone(s): Home: Cell: Work:

Email address:

Guardian/Person Responsible for Payment (circle one): self parent spouse 3rd party/Church

Parent/Spouse Name (if applicable):

**EMERGENCY CONTACT INFORMATION (please list two people in case of emergency)**

Name: Relationship:

Cell phone: Work phone: Home phone:

Name: Relationship:

Cell phone: Work phone: Home phone:

**PRIMARY CARE PHYSICIAN AND/OR PSYCHIATRIST**

**Physician:**  Phone:

**Psychiatrist:** Phone:

Signature here indicates permission for Diana B. Bryant, LMFT to contact the above listed physician(s) for the purpose of client care coordination:

**EMPLOYMENT INFORMATION:**

Client: Spouse:

***The remainder of this form must be completed prior to the first session or with the assistance of your therapist. If you have questions, please ask.***

**MEDICAL HISTORY**

Please describe your physical health (check one): excellent\_\_ good\_\_\_\_ fair \_\_\_\_\_ poor \_\_\_\_\_

Allergies? Yes\_\_\_\_ No \_\_\_\_\_ If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications:

Drug Dosage Purpose Doctor

**FAMILY INFORMATION: Please list your immediate family members, ages, relationship, and if they live with you.**

**Name Age Relationship Live with you?**

If married, number of years:

Other significant relationships (names/relationship only):

**COUNSELING HISTORY**

Have you ever been to counseling for any reason? Yes\_\_\_\_\_ No \_\_\_\_\_\_

If yes, for what reason?

Who was your counselor?

How long did you attend?

Have you ever been hospitalized for mental illness or substance abuse? Yes \_\_\_\_\_ No \_\_\_\_\_\_

If yes, for what reason?

How long were you in treatment?

Facility Name: Dates of treatment:

When you were discharged, did you attend outpatient counseling? Yes\_\_\_\_\_ No \_\_\_\_\_\_\_

Name of counselor:

**LIFE HISTORY (issues, circumstances, problems – past or present)**

**Losses – circle all that apply**

Death of family member divorce/separation broken engagement

Miscarriage/abortion/infertility bankruptcy homelessness career/job loss

**Victimizations – circle all that apply**

Child or spousal abuse: physical verbal emotional sexual

Abandonment rape/assault suicide/suicide attempt

Major illness due to: disease or accident physical disability

**Problems (that currently concern or worry you)**

**Relationships with:**

Spouse parents children siblings friends extended family

Co-worker teachers

**Other problems:**

Infidelity substance use (alcohol/street drugs/prescription drugs)

Eating issues (binging/purging/excessive dieting)

Depression anger anxiety stress grief fear loneliness

***Current Symptoms (as they apply to you today – circle all that apply)***

**Mood:** sad elated hopeless low energy poor concentration angry

**Anxiety:** worry panic fearfulness compulsive

**Thought:** depression hallucinations obsessive distractible

**Behavior:** aggressive disorganized compulsive

**Sleep** (describe)**:**

**Appetite** (describe)**:**

**Other symptoms not listed:**

***Intense Emotional Distress: Explain below anything that is currently happening or has happened in the last two weeks.***

Suicidal thoughts/plans/attempts: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Homicidal thoughts/plans/attempts:

Desire to cause pain to self or others:

In fear for own life or own safety:

Too depressed to care for self or family:

*Therapist use only: reviewed in session – initial here \_\_\_\_\_\_\_\_\_\_ date/time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Briefly state why you are coming to counseling:**

**State three goals you hope to accomplish during counseling:**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**THE CONTENTS OF THIS SCREENING FORM ARE CONFIDENTIAL AND WILL NOT BE RELEASED WITHOUT WRITTEN PERMISSION FROM CLIENT.**

**PLEASE RETURN FORM PRIOR TO FIRST SESSION.**

**THANK YOU!**