CONSULTATION FORM

Please provide the following information and answer the questions below to the best of your ability. Please note: information you provide here is protected as confidential information. Please fill out this form and bring it to me your first session.

Name: _____
(Last) ***(First)*** ***(Middle)***

Birth Date: _____ /_____ /_____ **Age:** _____

Gender Identity: _____ **Sexual Orientation:** _____

Marital Status: *Never Married ( ) Domestic Partnership ( ) Married ( )*
Separated ( ) Divorced ( ) Widowed ( ) (***Check Appropriately)***

Child(ren)/Age(s): ***(If Any)*** _____

Address: _____
(Street and Number)

_____
(City) ***(State)*** ***(Zip)***

Phone *(Home):* ( ) ***May I leave a message?*** Yes ( ) No ( )
Cell/Other Phone: ( ) ***May I leave a message?*** Yes ( ) No ( )

E-mail: _____
May I email you? Yes ( ) No ( )

Please Note: Email correspondence is not considered to be a confidential medium of communication.

Would you like me to add your email to my biweekly Anxiety-Blaster newsletter?
Yes ( ) No ( )

***Please Note:** Your email will never be shared with any third party.

How Did You Hear About Me?*:*

_____

Have You Previously Received Any Type Of Mental Health Services (Psychotherapy, Psychiatric Services, Life Coaching, etc.)?
Yes ( ) No ( )

Previous Therapist/Life Coach/Practitioner:

_____

(Name and Contact)

Are You Currently Taking Any Prescription Medication? Yes ( ) No ( )

Please State: ***(If Yes)*** _____

Have You Ever Been Prescribed Psychiatric Medication? Yes ( ) No ( )
Please List Dates ***(If Yes):*** _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. **How Would You Rate Your Current Physical Health Status?** ***(Please Check)***

Poor ( ) *Unsatisfactory ( )* *Satisfactory ( )* *Good ( )* *Very good ( )*

Please List Any Specific Health Problems You Are Presently Experiencing:

_____

2. **How Would You Rate Your Sleeping Habits Over The Last Month?** ***(Please Check)***

Poor ( ) *Unsatisfactory ( )* *Satisfactory ( )* *Good ( )* *Very good ( )*

Please List Any Specific Sleep Problems You Are Currently Experiencing:

_____

3. **How Many Times Per Week Do You Generally Exercise?** _____

What Type? (If Yes) _____

4. **Any Significant Changes With Your Appetite Or Eating Patterns?** *(If Yes, State):*

_____

5. **Are You Currently Experiencing Sadness, Grief Or Depression?**
Yes ( ) No ( )

If yes, for Approximately How Long? _____

6. **Are You Currently Experiencing Anxiety, Panic Attacks Or Have Any Phobias?**
Yes ( ) No ( )

If Yes, When Did You Begin Experiencing This? _____

7. **Are You Currently Experiencing Chronic Pain**? Yes ( ) No ( )

If Yes, Please Describe _____

8. **Do You Drink Alcohol More Than Once A Week?** Yes ( ) No ( )

9. **How Often Do You Engage In Recreational Drug Use?**

Daily ( ) Weekly ( ) Monthly ( ) Infrequently ( ) Never ( )

10. **Are You In A Romantic Relationship?** Yes ( ) No ( )

If Yes, For How Long? _____

On A Scale Of 1-10, How Would You Rate Your Relationship? _____

11. **What Significant Life Changes Or Stressful Events Have You Experienced Recently?**

If Any, Please State:

_____

FAMILY MENTAL HEALTH HISTORY

In this section, identify if there is a Family Mental Health History, and indicate the family member's relationship to you as provided in the table below (father, mother, grandmother, uncle, etc.).

S/N	MENTAL HEALTH HISTORY	OPTION (Yes or No)	FAMILY MEMBER
	Alcohol/Substance Abuse		
	Domestic Violence		
	Anxiety		
	Depression		
	Obsessive Compulsive Behavior		
	Suicide Attempts		
	Eating Disorders		
	Schizophrenia		
	Obesity		
	Any Other?		

ADDITIONAL INFORMATION:

1. **Are you currently employed?** Yes ( ) No ( )

If Yes, What Is Your Current Employment Situation?

_____

Do you enjoy your work? Is There Anything Stressful About Your Current Work?

_____

_____

2. **Do You Consider Yourself To Be Spiritual Or Religious**? Yes ( ) No ( )

If Yes, Describe Your Faith Or Belief:

_____

3. **What Do You Consider To Be Some Of Your Strengths?**

_____

_____

_____

4. **What Do You Consider To Be Some Of Your Weaknesses?**

_____

_____

_____

5. **What Would You Like To Accomplish Out Of Your Time In Therapy/Life Coaching?**

_____

_____

_____