General

Name _____ Date_____

Address _____

Home phone _____ Cell phone_____

Work phone _____ Fax _____

E-mail _____ Referred by _____

Age _____ Date of birth _____

Gender_____ Preferred pronouns_____

Marital status _____ Educational level _____

Occupation _____ Spiritual/Religious Affiliation_____

Emergency contact information _____

Areas of Concern

Do you have any specific goals for this group? _____

_____

_____

Do you have any particular concerns/fears with regard to group? _____

_____

_____

Psychological History

Do you have an individual therapist? If so, what is their name and contact information? _____

_____

Are you willing to sign a release of information so I can contact your former providers?

Yes _____ No _____

If not, why? _____

_____

Are you currently taking any prescription medications? _____

Therapy | Connection | Healing

Prescribed by whom? _____

How long have you been on the medications? _____

Medical History

Have you ever been diagnosed with a serious illness? Please describe _____
_____

Do you have any medical conditions that may affect your mental health treatment? _____
_____

Please describe your overall health today. _____

_____

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe. _____
_____

Substance Use History

Have you ever been in a 12-step program or other recovery program? Please describe.
_____
_____

Do you smoke? _____ How much? _____ For how long? _____ Do you drink alcohol? _____ On average, how much alcohol do you consume in a week?_____

Do you currently use illegal drugs? Please describe your use _____
_____

Have you ever used illegal drugs? Please describe. _____
_____

Other Information

Please feel free to include any other information that you believe is relevant to your mental health treatment, not previously requested. _____
_____

_____

_____