Please provide the following information and answer the questions below.
Please note: information you provide here is protected as confidential information.

Name _____

Nickname or Preferred Name:

Name of parent/guardian (if under 18 years):

_____

Your Birth Date: _____ /_____ /_____ Age: _____Gender:_____

Address: _____ City_____ State_____ Zip_____

Home Phone: _____ May we leave a message? ____ Yes ___ No

Cell/Other Phone: _____ May we leave a message? ____ Yes ___No
May we text? ____Yes ___ No

Email Address_____ May we email you? ____ Yes ____ No

*Please note: Email and text correspondence is not considered to be a confidential medium of communication.

In case of an Emergency who can I contact?

Emergency Contact_____

Phone_____ Relationship to you_____

Employer Name and Address_____
Work Phone_____
Insurance Co_____ Policy Number _____

Insurance Co. Phone Number_____Policy Holders Name_____

Policy Holders Date of Birth_____ Relationship_____

Address (if different from above)
_____

Secondary Insurance_____ Policy number_____

I understand that health and accident insurance policies are an arrangement between and insurance carrier and myself. I hereby authorize payment of medical benefits billed to my insurance company and that any amount authorized is paid directly to the Francine D Pritt, MS, LPC, NCC's office. I hereby accept responsibility for payment for any service provided to me that is not covered by my insurance. I also accept responsibility for all copayments, deductibles, and coinsurances that my insurance company assigns as my responsibility. _____ (initials)

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

NAME:_____ **DATE**_____ **CHART #:**_____

1, Current symptoms/issues: (check ones that apply)

- ☐ Depressed mood, feeling sad
- ☐ Decreased energy/lacking motivation
- ☐ Lack of interest/enjoyment
- ☐ Frequent crying
- ☐ Suicidal thoughts, thoughts of death
- ☐ Grief/loss issues
- ☐ Hopelessness/helplessness
- ☐ Worthlessness
- ☐ Guilt/Inferiority feelings
- ☐ Difficulty making decisions
- ☐ Memory problems
- ☐ Withdrawing/isolating self

- ☐ Irritability/anger
- ☐ Elevated mood
- ☐ Increased energy
- ☐ Mood swings
- ☐ Increased self esteem
- ☐ Increased goal direction
- ☐ Temper problems/poor control
- ☐ Racing thoughts

- ☐ Past use of chemicals
- ☐ Current use of chemicals

- ☐ Shyness/sensitive to criticism
- ☐ Anxiousness/excessive worry
- ☐ Panic attacks
- ☐ Obsessive thoughts/behaviors
- ☐ Compulsive thoughts/behaviors
- ☐ Pounding or racing heart
- ☐ Dizziness
- ☐ Sweating
- ☐ Nausea/vomiting
- ☐ Hot/cold flashes
- ☐ Fear of dying
- ☐ Shortness of breath
- ☐ Trembling
- ☐ Choking
- ☐ Numbness/tingling
- ☐ Fear of situation/places
- ☐ Fear of going out of control

- ☐ Difficulty concentrating
- ☐ Impulsiveness
- ☐ Poor decision making
- ☐ Difficulty paying attention
- ☐ Excessive activity
- ☐ Procrastination/difficulty getting started/completing work

- ☐ Disorganized thoughts
- ☐ Difficulty with thinking
- ☐ Delusions
- ☐ Unusual beliefs or thoughts
- ☐ Hearing voices
- ☐ Seeing things
- ☐ Paranoia/suspicious of others
- ☐ Feeling disconnected
- ☐ Flashbacks
- ☐ Nightmares

- ☐ Physical complaints
- ☐ Coexisting medical conditions
- ☐ Increased appetite
- ☐ Decreased appetite
- ☐ Binging, purging, restricting
- ☐ Difficulty with sleep
- ☐ Sleeping excessively

- ☐ Emotional/Verbal abuse
- ☐ Physical
- ☐ Sexual abuse

Symptoms have been present for: ☐ Less than one month ☐ 1-6 months ☐ 7-11 months ☐ One year or more

Are you having any suicidal/homicidal thoughts? ☐ Yes ☐ No Explain:_____

Do you have a plan for suicide/homicide? ☐ Yes ☐ No Explain:_____

Are you taking your medications everyday as prescribed? ☐ Yes ☐ No If no, how are you taking them?

_____

2. List all meds you are taking

Name of Med:	*Dose:*	*Times a day:*
	Time of day taken:	

Have you ever used anyone else's medications? ☐ No ☐ Yes_

3. Please describe the current complaint or problem as specifically as you can, in your own words, and how long this has occurred:

_____
_____

4. Have you previously received any type of counseling services (psychotherapy, psychiatric, hospital stays, drug/alcohol treatment, self-help groups (AA, Al- Anon, NA etc.)? __ No __Yes

Reason, Practitioner /Hospital and Dates: _____

5. Are you currently in a romantic relationship? __No __ Yes

If yes, for how long? _____

On a scale of 1-10 (10 highly positive), how would you rate your relationship? _____

Marital Status: __Never Married __Domestic Partnership __ Married ____ how many times married

__ Separated __Divorced__ Widowed

Please list any children/age:

_____

6. Are you currently employed? _____No _____ Yes

7. What is the highest educational level you have completed? _____

8. Are you a student? __Yes __No Grade or University status _____

9. Are you involved in any active or past cases? (traffic, civil, criminal) _____Yes _____NO

If yes, please describe your past or current history_____

10.Military experience? ____ Yes ____ No Combat experience? ____Yes ____No

Are you or have you been a member/ public/government service ex: Police, Fire etc. _____ Yes ____ No

#_____

FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following.
If yes, please indicate the family member's relationship to you in the space provided (father, maternal grandmother, paternal uncle, etc.).

Circle *yes* or *no* then list family member:

Alcohol/Substance Abuse yes/no

Anxiety yes/no

Depression yes/no

Obsessive Compulsive Behavior yes/no

Domestic Violence yes/no

Eating disorders yes/no

Obesity yes/no

Other Mood disorders (ex: Bipolar) yes/no

Schizophrenia yes/no

Suicide Attempts yes/no

What cultural/ethnic/or other do you identify with? _____

Are you experiencing any problems due to cultural, ethnic, social or other ? __ Yes _ NO

If yes,
describe_____

Do you consider yourself to be spiritual or religious? ____Yes _____No

If yes, please describe your faith/belief_____

SOCIAL HISTORY

1. Describe your relationship with peers and/or friends: _____

2. How would you describe your social support network? (Who can you speak/confide in comfort you?)

_____

3. Describe your hobbies/interests_____

1. What do you consider to be some of your strengths? _____

_____

2. What do you consider to be some of your weakness? _____

_____

3. What would you like to accomplish out of your time in therapy?

_____

_____

Who were you referred by: _____

Signature of Client or Guardian_____

Date_____

For Staff Use, additional Comments:

_____

_____

Signature of Therapist/Credentials _____

Date _____