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Date: _____

Name: _____ **Parent/Guardian _____**
(if under 18)

Name of Partner _____ **Responsible Party _____**
(if Couples Therapy) **(If different from patient)**

Address: _____ **Billing Address: _____**

_____ **_____**

Home Phone: ( ) **May I leave a message? □ Yes □ No**

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

E-mail: _____ **May I email you? □ Yes □ No**

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

Birth Date: ____ /____ /____ Age: _____ **Social Security Number _____-____-_____**
(if submitting for insurance reimbursement)

Marital Status: □ Never Married □ Domestic Partnership □ Married □ Separated/ Divorced □ Widowed

Please list any children/age(s): _____

Employment Status _____ **Profession _____** **Employer_____**

Emergency Contact: Name: _____ **Relationship: _____**

Address: _____ **Telephone: _____**

Who referred you to Dr. Clark? _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No □ Yes, previous therapist/practitioner:

Are you currently taking any prescription medication? □ No □ Yes, Please list:

Have you ever been prescribed psychiatric medication?
□ No □ Yes, Please list and provide dates:

How would you rate your current physical health? (please circle) Poor Unsatisfactory Satisfactory Good Very Good
Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits? (please circle) Poor Unsatisfactory Satisfactory Good Very Good
Please list any specific sleep problems you are currently experiencing:

How many times per week do you generally exercise? _____
What types of exercise to you participate in?

Please list any difficulties you experience with your appetite or eating patterns:

Are you currently experiencing overwhelming sadness, grief, or depression?

□ No □ Yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks, or have any phobias?

□ No □ Yes, please describe: _____

Are you currently experiencing any chronic pain?
□ No □ Yes, please describe: _____

Do you drink alcohol more than once a week? □ No □ Yes, drinks per week? _____

How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

Are you currently in a romantic relationship? □ No □ Yes, for how long? _____

On a scale of 1(very poor) to10 (extremely satisfying), how would you rate your relationship? _____

What significant life changes or stressful events have you experienced recently?

What chronic stressors exist in your personal and professional life?

Please list a few of your strengths?

Please list a few of your areas for growth?

What are you hoping to accomplish through therapy?

FAMILY MENTAL HEALTH HISTORY: In the section below, identify any family history of the following by indicating the family member's relationship to you (father, grandmother, uncle, etc.).

Alcohol/Substance Abuse	**□ No □ Yes, who?**
Anxiety	**□ No □ Yes, who?**
Depression	**□ No □ Yes, who?**
Domestic Violence	**□ No □ Yes, who?**
Eating Disorders	**□ No □ Yes, who?**
Obesity	**□ No □ Yes, who?**
Obsessive Compulsive Behavior	**□ No □ Yes, who?**
Schizophrenia	**□ No □ Yes, who?**
Suicide Attempts	**□ No □ Yes, who?**

Thank you for taking the time to answer these important questions.
I look forward to getting to know you better.