



DEMOGRAPHICS & BACKGROUND

ADULT

Counseling I am seeking: Individual Couples Family

About Me	
Date of Birth: ____/____/____ Name: _____ Preferred Name: _____ My Gender Identity is (circle all that apply): Woman, Man, Trans MTF, Trans FTM, Genderqueer, Other Preferred Gender Pronouns (circle all that apply): She/Her, He/His, They/Them/Their, Zie/Hir, Other My Sex Assigned at Birth is (circle all that apply): Female, Male, Intersex, Other My Sexual Orientation is (circle all that apply): Asexual, Bisexual, Gay, Heterosexual, Lesbian, Queer, Questioning, Other Address: _____ City: _____ Zip: _____ Email: _____ I would like to receive email or text communication from MySpectrum: <input type="checkbox"/> Yes <input type="checkbox"/> No Home #: _____ Cell #: _____ Work #: _____ Other #: _____ On what number may we leave a confidential message : <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Other	Name of Employer (1): _____ Address: _____ City: _____ Zip: _____ Name of Employer (2): _____ Address: _____ City: _____ Zip: _____ OR: <input type="checkbox"/> I am self-employed <input type="checkbox"/> I am unemployed <input type="checkbox"/> I am retired I am: Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> In a committed relationship <input type="checkbox"/> How many people live in your household? _____ I am (circle all that apply): African-American, Black, African-Caucasian, African-Hispanic, American Indian, Native American, Eskimo, Asian and African-American, Asian, Pacific Islander, Asian-American, Asian-Hispanic, Hispanic origin, Latino, Iranian, Israeli, Korean, Unknown, Unwilling to identify by race, White/Indo-European

How did you hear about MySpectrum?

- | | | | |
|---|--------------------------|------------------|--------------------------|
| Another Counseling or Mental Health Provider | <input type="checkbox"/> | Internet Search | <input type="checkbox"/> |
| Referral from relative, friend, or MySpectrum Client | <input type="checkbox"/> | Psychology Today | <input type="checkbox"/> |
| Therapist, Psychiatrist, Physician, or Hospital Staff | <input type="checkbox"/> | Other | <input type="checkbox"/> |

EMERGENCY CONTACT INFO

Notify: _____ Phone: _____
 Relationship to client: _____

Notify: _____ Phone: _____
 Relationship to client: _____



**HEALTH AND
MEDICAL**

Primary Care Physician: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Please list any medical problems: _____

Please list any current medications (name and dosage): _____

If you have been given a mental health diagnosis in the past, please list the diagnoses:

PREVIOUS COUNSELING

Please list any previous counseling, psychiatric treatment, or residential/in-patient care you have received:

With Whom: _____

Dates: _____

Reason(s): _____

With Whom: _____

Dates: _____

Reason(s): _____

With Whom: _____

Dates: _____

Reason(s): _____

With Whom: _____

Dates: _____

Reason(s): _____

With Whom: _____

Dates: _____

Reason(s): _____

ADDITIONAL INFO

Are you required by a court of law to receive counseling as part of a legal proceeding? Yes No

Have you obtained services from MySpectrum before? Yes No If yes, when? _____

My top reason(s) for coming to therapy today are:

LEGAL HISTORY

Are you facing any current or future civil or criminal legal issues? Yes No

Have you been subject to a restraining order in the last 10 years? Yes No

Have you filed for a restraining order in the last 10 years? Yes No

Have you experienced any legal issues relating to divorce or child custody in the last 10 years? Yes No

Do you expect the possibility of legal issues relating to divorce or child custody in the next 5 years? Yes No

TRAUMA/ABUSE HISTORY

Have you ever experienced a severe trauma? Yes No Maybe

If yes or maybe, please explain: _____

Have you ever been physically or sexually abused? Yes No Maybe

If yes or maybe, please explain: _____

Have you ever been emotionally or mentally abused? Yes No Maybe

If yes or maybe, please explain: _____

RELIGIOUS/SPIRITUAL INFORMATION

Is Faith, Religion or Spirituality important to you? Yes No Maybe. If yes or maybe, please explain: _____

PERSONAL STRENGTHS

Please list three things that you are proud of:

1)

2)

3)

Please list three personal strengths:

1)

2)

3)

Symptom Assessment

Please give as accurate account as you can and if you have any questions or concerns, we invite you to discuss them with your Therapist.

(✓ your concerns)

I AM EXPERIENCING...	Never	Seldom	Often	Always	For how long?
Frequent worry or tension					
Fear of many things					
Discomfort in social situations					
Feelings of guilt					
Phobias: unusual fears about specific things					
Panic Attacks: Sweating, trembling, shortness of breath, heart palpitations					
Recurring, distressing thoughts about a trauma					
“Flashbacks” as if reliving the traumatic event					
Avoiding people/places associated with trauma					
Nightmares about traumatic experience					
I AM FEELING...	Never	Seldom	Often	Always	For how long?
Decreased interest in pleasurable activities					
Social Isolation, Loneliness					
Suicidal Thoughts					
Bereavement or Feelings of Loss					
Changes in sleep (too much or not enough)					
Normal, daily tasks require more effort					
Sad, hopeless about future					
Excessive feelings of guilt					
Low self-esteem					
I NOTICE...	Never	Seldom	Often	Always	For how long?
I am Angry, Irritable, hostile					
I feel euphoric, energized and highly optimistic					
I have racing thoughts					
I need less sleep than usual					
I am more talkative					
My moods fluctuate: go up and down					
I HAVE...	Never	Seldom	Often	Always	For how long?
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tell me					
Intrusive or strange thoughts					
Obsessive Thoughts					
Been hearing voices when alone					
Problems with my speech					

I HAVE...	Never	Seldom	Often	Always	For how long?
Risk Taking behaviors					
Compulsive or repetitive behaviors					
Been acting without concern for consequence					
Been physically harming myself					
Been violent toward other(s)					
I USE THE FOLLOWING....	Never	Seldom	Often	Daily	For how long?
Alcohol					
Nicotine (Cigarettes)					
Marijuana					
Cocaine					
Opiates					
Sedatives					
Hallucinogens					
Stimulants					
Methamphetamines					
MY EATING INVOLVES...	Never	Seldom	Often	Always	For how long?
Restriction of food consumption					
Bingeing and Purging					
Binge Eating					
A lot of weight loss or gain					
I HAVE...	Never	Seldom	Often	Always	For how long?
Concern about my sexual function					
Discomfort engaging in sexual activity					
Questions about my sexual orientation					
EMPLOYMENT & SELF-CARE	Never	Seldom	Often	Always	For how long?
I have problems getting/keeping a job					
I have problems paying for basic expenses					
I am afraid of becoming homeless					
I have problems accessing healthcare					

PERSONAL AND FAMILY HISTORY

Have you or a close relative ever been hospitalized for a psychiatric illness? **Yes** **No**

Does anyone in your family have a mental illness? **Yes** **No**

Has anyone in your family ever attempted or committed suicide? **Yes** **No**

Does anyone in your family have a substance abuse problem? **Yes** **No**

Have you ever been arrested? **Yes** **No**

If “yes” to any of the above, please briefly explain:

1) How well you are doing on your job: (✓)

0 1 2 3 4 5 6 7 8 9
 Not Working Cannot Function Serious Problems Moderate Problem Mild Problems No Problems

2) How well you are doing in your marital/significant other relationship: (✓)

0 1 2 3 4 5 6 7 8 9
 N/A Cannot Function Serious Problems Moderate Problem Mild Problems No Problems

3) How well you are doing in your family relationships: (✓)

0 1 2 3 4 5 6 7 8 9
 N/A Cannot Function Serious Problems Moderate Problem Mild Problems No Problems

4) How well you are doing in relationships with people outside your family: (✓)

0 1 2 3 4 5 6 7 8 9
 N/A Cannot Function Serious Problems Moderate Problem Mild Problems No Problems

5) Please rate your current physical health: (✓)

0 1 2 3 4 5 6 7 8
 Very Poor Excellent

6) Please rate your general happiness and well-being: (✓)

0 1 2 3 4 5 6 7 8
 Very Poor Excellent

Please sign and date this form as an acknowledgement of completion to the best of your ability:

Signature

Date