SAVE

DEMOGRAPHICS & BACKGROUND

ADULT

Counseling I am seeking: ☐ Individual ☐ Couples ☐ Family

About Me

Date of Birth: ____/____/____

Name: _____

Preferred Name: _____

My Gender Identity is (choose all that apply):
Woman, Man, Trans MTF, Trans FTM, Genderqueer, Other
☐ ☐ ☐ ☐ ☐ ☐

Preferred Gender Pronouns (choose all that apply):
She/Her, He/His, They/Them/Their, Zie/Hir, Other
☐ ☐ ☐ ☐ ☐

My Sex Assigned at Birth is (choose all that apply):
Female, Male, Intersex, Other
☐ ☐ ☐ ☐

My Sexual Orientation is (choose all that apply):
Asexual, Bisexual, Gay, Heterosexual, Lesbian, Queer, Other
☐ ☐ ☐ ☐ ☐ ☐ ☐

Address: _____

City/State: _____ Zip: _____

Email: _____

I would like to receive email or text communication from MySpectrum: ☐ **Yes** ☐ **No**

Home #: _____ _____

Cell #: _____ _____

Work #: _____ Other #: _____

On what number may we leave a **confidential message**:
☐ Home ☐ Cell ☐ Other

Name of Employer (1): _____
Address: _____
City: _____ Zip: _____

Name of Employer (2): _____
Address: _____
City: _____ Zip: _____

OR:
☐ I am self-employed ☐ I am unemployed
☐ I am retired

I am:
Single ☐
Married ☐
Divorced ☐
In a committed relationship ☐

How many people live in your household? _____

I am (choose all that apply):
African-American/ Black ☐
American Indian/ Native American ☐
Asian/Asian-American/ Pacific Islander ☐
Hispanic-American/Latinx ☐
Middle Eastern ☐
Unknown ☐
Unwilling to identify by race ☐
White/Indo-European ☐
Specify (if wished) _____

How did you hear about MySpectrum?

Another Counseling or Mental Health Provider	☐	Internet Search	☐
Referral from relative, friend, or MySpectrum Client	☐	Psychology Today	☐
Therapist, Psychiatrist, Physician, or Hospital Staff	☐	Other	☐

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 every 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