

Frequency and amount of alcohol / recreational drug use:

Amount of caffeine use _____

Quantity of cigarette smoking _____

Frequency and type of exercise _____

Amount of time in nature _____

Amount of sleep per night _____

PREVIOUS COUNSELING EXPERIENCE

Have you been in counseling before? Yes ___ No ___ If yes, please describe below:

1. Therapist's name _____ Approx. duration & date last seen _____

2. Therapist's name _____ Approx. duration & date last seen _____

Psychiatric hospitalizations? Yes ___ No ___ Dates _____

CURRENT REASON for SEEKING COUNSELING

Please describe briefly what has prompted you to seek counseling now, what changes you are hoping to make via counseling:

Please check any of the following symptoms you have experienced in the past month:

- | | | |
|---|--|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Feeling hopeless | <input type="checkbox"/> Obsessions or compulsions |
| <input type="checkbox"/> Extreme sadness | <input type="checkbox"/> Trouble concentrating | <input type="checkbox"/> Change in sleep habits |
| <input type="checkbox"/> Memory problems | <input type="checkbox"/> Lack of energy | <input type="checkbox"/> Change in eating habits |
| <input type="checkbox"/> Weight changes | <input type="checkbox"/> Feeling stressed | <input type="checkbox"/> Feelings of extreme happiness |
| <input type="checkbox"/> Self-esteem problems | <input type="checkbox"/> Easily irritated | <input type="checkbox"/> Change in sexual interest or function |
| <input type="checkbox"/> Perfectionism | <input type="checkbox"/> Feeling guilty | <input type="checkbox"/> Problems getting along w/ family |
| <input type="checkbox"/> Problems with anger | <input type="checkbox"/> Feeling fearful | <input type="checkbox"/> Trouble performing your job |
| <input type="checkbox"/> Feeling anxious | <input type="checkbox"/> Acting violently | <input type="checkbox"/> Lack of enjoyment in usual activities |
| <input type="checkbox"/> Feeling tearful | <input type="checkbox"/> Muscle tension | <input type="checkbox"/> Impulsive behaviors |
| <input type="checkbox"/> Physical pain | <input type="checkbox"/> Feelings of panic | <input type="checkbox"/> Poor judgment |
| <input type="checkbox"/> Thoughts of hurting yourself or others | | <input type="checkbox"/> Thoughts of killing yourself or others |

Is there anything else you want me to know? _____
