SANDY GRAHAM, MS, PLLC

NEW CLIENT INFORMATION

DEMOGRAPHIC		
Name:	Date:	
Date of Birth:	Relationship Status:	
Age:	SSN:	
# of Dependents:	Gender: M / F	
Home Phone:	Is it ok to leave messages for you at this number? Y / N	
Cell Phone:	Is it ok to leave messages for you at this number? Y / N	
Work Phone:	Is it ok to leave messages for you at this number? Y / N	
Email:	Is it ok to email you? Y / N	
Mailing Address:		
City:	State:	Zip;
EMERGENCY CONTACT		
Name:	Relationship:	
Home phone:	Cell phone:	
Work phone:	Other number:	
EMPLOYMENT / FINCANCIAL		
CURRENT OCCUPATIONAL STATUS: (I.E., F/T, P/T, SELF-EMPLOYED, UNEMPLOYED STUDENT, RETURNING TO WORK):		
CURRENT EMPLOYER:	**POSITION TITLE:**	
TYPE OF WORK:		

Have you been in therapy before or received any prior professional assistance for your concerns? If so, please describe problems, services and dates:

_____

_____

_____

PLEASE TELL ME HOW YOU FOUND ME	
REFERRAL	**INTERNET**
(Please provide contact information if it is a professional referral)	☐ My website ☐ Google ☐ Yahoo ☐ Bing ☐ Find a Therapist ☐ Find Counseling ☐ Network Therapy ☐ Psychology Today ☐ Theravive ☐ Good Counselors ☐ Other: _____

CURRENT PROBLEMS & CONCERNS

What concern(s) brings you in?

When did this concern begin (give dates)?

Please describe significant events occurring at that time, or since then, which may relate to the development or maintenance of this concern:

Are you having any difficulties/stressors in your current job? If so, please briefly describe those difficulties.

What do you hope to accomplish in counseling?

What kind of obstacles could get in the way?

Behavior – circle any of the following behaviors that apply to you:

Overeat	Suicidal attempts	Can't keep a job	Take drugs	Compulsions
Trouble sleeping	Vomiting	Smoke	Take too many risks	Odd behavior
Withdrawal	Lack of motivation	Drink too much	Nervous tics	Eating problems
Work too hard	Procrastination	Sleep disturbance	Crying	Impulsive reactions
Phobic avoidance	Outbursts of temper	Loss of control	Aggressive behavior	Concentration difficulties
Compulsive Sexual Behaviors? Specify:		Relationship Difficulties? Specify:		

Are there any specific behaviors, actions, habits that you would like to change?

_____

_____

_____

_____

_____

Feelings – circle any of the following feelings that apply to you:

Angry	Guilty	Unhappy	Annoyed	Happy	Bored	Sad
Conflicted	Restless	Depressed	Regretful	Lonely	Anxious	Hopeless
Contented	Fearful	Hopeful	Excited	Panicky	Helpless	Optimistic
Energetic	Relaxed	Tense	Envious	Jealous	Others:	

Physical – circle any of the following symptoms that apply to you:

Headaches	Stomach trouble	Skin problems	Dizziness	Tics
Dry mouth	Palpitations	Fatigue	Burning or itchy skin	Muscle spasms
Twitches	Chest pains	Tension	Back pain	Rapid heart beat
Sexual disturbances	Tremors	Unable to relax	Fainting spells	Blackouts
Bowel disturbances	Hear things	Excessive sweating	Tingling	Watery eyes
Visual disturbances	Numbness	Flushes	Hearing problems	Don't like being touched

Biological factors:

Do you have any current concerns about your physical health? Please specify:

_____

_____

_____

_____

_____

Is a doctor treating you for any physical problems at this time? Please Specify:

_____

_____

_____

_____

Physicians name: _____ Phone: _____

Please list medicines you are currently taking, or have taken during the past 6 months (include all medicines, supplements, herbal remedies, etc. that were prescribed or taken over the counter):

PRESCRIPTION MEDICATIONS					
MEDICATION	**DR.**	**DOSE**	**FREQUENCY**	**HOW LONG?**	**PURPOSE**
			`		

OVER THE COUNTER MEDICATIONS / SUPPLEMENTS ETC.				
MEDICATION/SUPPLEMENT	**DOSE**	**FREQUENCY**	**HOW LONG?**	**PURPOSE**
		`		

Do you get regular exercise? If so, what type and how often?

_____

_____

_____

_____

_____

Check any of the following that apply to you:

	Never	Rarely	Frequently	Very Often		Never	Rarely	Frequently	Very Often
Marijuana					Heart problems				
Tranquilizers					Nausea				
Sedatives					Vomiting				
Aspirin					Insomnia				
Cocaine					Headaches				
Painkillers					Backaches				
Alcohol					Early morning awakening				
Coffee					Fitful sleep				
Cigarettes					Binge / Purge				
Narcotics					Poor appetite				
Stimulants					Eat “junk foods”				
Hallucinogens					Lack of interest in activities				
Diarrhea					Constipation				
Compulsive Exercise					High blood pressure				
Use Laxatives					Allergies				

FAMILY OF ORIGIN INFORMATION

Identify your major caregivers:

NAME	RELATIONSHIP

List in birth order the children in your family of origin (starting with the oldest on top). Include step siblings, etc. Use a noun or adjective to describe each person. Include yourself and deceased siblings (Indicate if the sibling is deceased.

NAME/RELATIONSHIP	AGE	DESCRIPTION

If you were adopted, at what age were you adopted? _____ At what age were you told? _____

List other adults who were involved in your childhood. Use a noun or adjective to describe each person.

ADULT / RELSTIONSHIP	DESCRIPTION

In the following questions, the terms mother and father are used to indicate biological or adoptive parents or mother/father substitutes. Regardless of the actual status or nature of the relationships the terms mother and father are being used to describe the primary caregivers. If you have multiple caregivers who where significant in your life, copy this page to include that information.

Is your mother living? Yes ____ No ____

If deceased, how old were you at the time of her death? _____

If the person you are labeling as your mother is not your biological mother describe your relationship to her>

_____
_____
_____
_____
_____
_____

Is your father living? Yes ____ No ____

If deceased, how old were you at the time of his death? _____

If the person you are labeling as your father is not your biological father describe your relationship to him and how you came to be with him.

_____
_____
_____
_____
_____
_____

Describe your parental living situation during your childhood. Describe divorces, periods of separation, deaths, etc.

_____
_____
_____
_____
_____
_____
_____
_____

List nouns and adjectives to describe your mother:

POSITIVE		NEGATIVE	

List nouns and adjectives to describe your father:

POSITIVE		NEGATIVE	

Describe yourself as a child:

What did you learn from your mother?

What did you learn from your father?

RELATIONSHIP HISTORY

Please describe your significant relationships other than family, beginning with the earliest. For relationship type enter marriage, friendship, romantic, or any adjectives that classify the nature of the relationship. In the narrative section describe, briefly, how the relationship started, how long it lasted and, if it is over, how it ended.

YOUR AGE	PARTNERS NAME	RELATIONSHIP TYPE	NARRATIVE