Tesfa-House Psychotherapy & Consulting.

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Please complete the following background information, leaving blank any item that you do not feel comfortable answering. Place a star (*) next to any items you would like to emphasize.

Name: _____ Date: ____ / ____ / ____

Date of Birth: ____ / ____ / ____

Address: _____ City _____ State _____ Zip _____

Preferred Phone: _____ ☐ Home ☐ Cell ☐ Other _____

May I contact you/leave a message at this number? ☐ No ☐ Yes

Email: _____

May I contact you at this email address? ☐ No ☐ Yes

Emergency Contact

Name: _____ Relationship: _____

Emergency Contact Phone Number: _____ ☐ Home ☐ Cell ☐ Other _____

Referred to Therapy by:
☐ Self ☐ Family Member ☐ Friend ☐ Medical Professional ☐ Other _____

Describe your main reason for seeking therapy at this time?

_____

_____

_____

Demographic Information

What is your age? _____

How do you identify your gender? _____

How do you identify your race? _____

How do you identify your ethnicity or heritage? _____

How do you identify your sexual orientation? _____

How would you describe relationship status? _____

What is your education level? _____

Are you a student (if Y, school/year/GPA)? _____

What is your employment status? _____

What is your current occupation? _____

Have you been in the military (if Y, where/when)? _____

If you were raised in a particular religious/spiritual tradition, please identify below:

_____

Please describe the role of religion/spirituality in your life currently:

_____

Prior Mental Health Treatment

Have you sought counseling/psychotherapy before? ☐ No ☐ Yes

If yes, please answer the following questions:

When? _____

How long? _____

With whom? _____

For what? _____

What did you find helpful or not helpful about your previous counseling/psychotherapy experience:

_____

Have you ever been hospitalized for psychiatric reasons? ☐ No ☐ Yes

If yes, please elaborate (when, duration, location, reason?): _____

_____

Have you ever experienced thoughts of harming yourself? ☐ No ☐ Yes

Have you engaged in self-injurious behaviors (i.e. cutting, burning, hair pulling, etc.)?
☐ No ☐ Yes: If yes, please elaborate:

Have you seriously considered attempting suicide in the past? ☐ No ☐ Yes

Have you attempted suicide in the past? ☐ No ☐ Yes: If yes, please elaborate: _____

_____

Medical Information

Do you have a primary care physician? ☐ No ☐ Yes

If yes, name: _____ Phone: _____

Date of last exam: ____ / ____ / ____

Please list any medical conditions that you have: _____

List any medications you are currently taking below:

Over-The-Counter Medications

Name	Dose	Frequency	Reason

Prescribed Medications

Name	Dose	Frequency	Reason	Prescribed by

Please list any disabilities that you have: _____

Alcohol and Substance Use

Do you consume alcohol? ☐ No ☐ Yes If so, how much? _____

Do you consume caffeine? ☐ No ☐ Yes If so, how much? _____

Do you smoke cigarettes? ☐ No ☐ Yes If so, how many? _____

Indicate what, if any, illicit or mood altering substances that you currently use or have used in the past.

_____

_____

Family History

Please describe the relationship status of your parents/guardians? _____

Siblings and Ages: _____

Children and Ages: _____

Have any of your family members experienced mental health concerns? If so, please indicate who, as well as treatment history.

_____

_____

_____

Presenting Concerns and Symptoms

Use the scale below to indicate the degree to which each area is of concern for you. Circle a number for each item.

0----------1----------2----------3----------4----------5

Minimal Concern **Significant Concern**

Sadness and depression: 0----------1----------2----------3----------4----------5

Grief and loss: 0----------1----------2----------3----------4----------5

Nervousness and anxiety: 0----------1----------2----------3----------4----------5

Obsessive behaviors: 0----------1----------2----------3----------4----------5

Feelings of stress: 0----------1----------2----------3----------4----------5

Feelings of frustration: 0----------1----------2----------3----------4----------5

Inconsistencies in mood: 0----------1----------2----------3----------4----------5

Thoughts of self-harm: 0----------1----------2----------3----------4----------5

Thoughts of harming others: 0----------1----------2----------3----------4----------5

Health concerns: 0----------1----------2----------3----------4----------5

Sexual concerns: 0----------1----------2----------3----------4----------5

Difficulty sleeping: 0----------1----------2----------3----------4----------5

Eating concerns: 0----------1----------2----------3----------4----------5

Body image: 0----------1----------2----------3----------4----------5

Substance and/or alcohol use: 0----------1----------2----------3----------4----------5

Traumatic experience(s): 0----------1----------2----------3----------4----------5

Sexual orientation: 0----------1----------2----------3----------4----------5

Spirituality: 0----------1----------2----------3----------4----------5

Family Relationships: 0----------1----------2----------3----------4----------5

Social Relationships: 0----------1----------2----------3----------4----------5

Romantic Relationships: 0----------1----------2----------3----------4----------5

Work: 0----------1----------2----------3----------4----------5

School: 0----------1----------2----------3----------4----------5

Financial issues: 0----------1----------2----------3----------4----------5

Legal issues: 0----------1----------2----------3----------4----------5

Other: _____ 0----------1----------2----------3----------4----------5

Signature: _____ Date: ____ / ____/ ____

I appreciate your openness in providing the above information and look forward to working with you.