

*Introspections*  
2512 SE Gladstone St., Suite 101  
Portland, OR 97202  
(503) 296-2910

Please fill out this form to help me know more about you. It will save us time during our sessions so we can focus on what's most important to you. You may omit any information that you do not wish to share. Please circle your answers unless otherwise indicated.

**SECTION I: IDENTIFYING INFORMATION**

Name \_\_\_\_\_ Date of Birth/Age \_\_\_\_\_ Gender F M FTM MTF Other  
Ethnicity \_\_\_\_\_ Street Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell phone or other \_\_\_\_\_ If I need to call you, is it okay  
to identify myself to whoever answers? Yes No Email address \_\_\_\_\_  
Emergency Contact/Relationship \_\_\_\_\_ Contact's Phone number(s) \_\_\_\_\_  
Education high school some college BA/BS MA/MS PhD/Other Doctorate  
If you have a degree, what was your major/specialization? \_\_\_\_\_  
Are you employed? Yes No Where and how much do you work? \_\_\_\_\_  
Do you enjoy your work? Yes No Are finances a major stressor for you? Yes No

**SECTION II: MEDICAL HISTORY**

Name and location of Physician \_\_\_\_\_  
Please list any significant illnesses, hospitalizations and injuries. \_\_\_\_\_  
\_\_\_\_\_  
Have you ever had a head injury of any kind? Yes No If so, when and how was it treated? \_\_\_\_\_  
\_\_\_\_\_  
Have you ever had memory losses/lapses or blackouts? Yes No  
Have you ever had treatment by a psychiatrist, psychologist or counselor? Yes No  
If yes, when? \_\_\_\_\_ Was it helpful? Yes No

Reason for prior treatment \_\_\_\_\_

Where were you treated? \_\_\_\_\_ Therapist's Name \_\_\_\_\_

Have you ever been hospitalized for psychiatric reasons? Yes No If yes, when and why? \_\_\_\_\_

Have you ever attempted suicide? Yes No If yes, when and how? \_\_\_\_\_

**SECTION III: SUBSTANCE USE**

Please indicate how much of the following substances you use in a typical week. Please fill in a number indicating how much you usually consume on that day Also indicate if you think you use too much, or think you have a problem with it.

SUBSTANCE	AMOUNT PER DAY OR WEEK	TOO MUCH? (Y/N)
Alcohol		
Caffeine		
Tobacco		
Marijuana		
Cocaine		
Sedatives		
Methamphetamines		
Other (specify)		

Do you use alcohol or drugs to (circle all that apply): Manage stress? To relax? To change mood?

For sleep?

If applicable, please list all medications you are now taking or have taken in the past three months, including birth control pills, vitamins, herbs and supplements.

MEDICATION	DOSAGE	WHY PRESCRIBED	HELPFUL? Y/N

**SECTION IV: DESCRIPTION OF PRESENTING PROBLEM**

**Please state why you decided to come for therapy:** \_\_\_\_\_

**Please state what you want to work on in therapy: (what do you want to be different?)** \_\_\_\_\_

**How long has this been a problem for you?** \_\_\_\_\_

**How would you estimate the severity of the problem?** Mild Moderate Serious Severe

**What symptoms are related to this problem? Please circle all that apply for you now:**

- overeating    restless    rapid heart rate    compulsive behaviors    taking drugs    depressed mood  
sweating    fears/phobias    odd behavior/thoughts    crying    trembling or shaking    anxiety  
recent weight loss    difficulty concentrating    shortness of breath    vomiting    recent weight gain  
low motivation    muscle tension    distrust    social withdrawal    aggressive behavior    outbursts of temper  
jumpy    family problems    feelings of worthlessness    nightmares    dizzy or lightheaded    chest pain  
stomach problems    easily distracted    fatigue/loss of energy    can't fall asleep    sleeping too much  
decreased need for sleep    obsessions    financial problems    problems with work/school    housing problems  
relationship problems    decreased sex drive    other sexual problems    experienced traumatic event    pain  
drinking alcohol/substance abuse    other: \_\_\_\_\_

**If applicable, please briefly describe any incidents or problems that may have triggered and/or been associated with this problem (e.g., relationship ending, loss of job, etc.):**

\_\_\_\_\_  
\_\_\_\_\_

**SECTION V: FAMILY OF ORIGIN INFORMATION**

	AGE	OCCUPATION	DECEASED?	QUALITY OF RELATIONSHIP (EXCELLENT, GOOD, FAIR, POOR)
MOTHER/STEPMOTHER				
FATHER/STEPFATHER				
BROTHER (S)				
SISTER (S)				

**Are your parents divorced?** Yes No

**Have any members of your family had problems with:** drugs alcohol depression anxiety

Suicide attempts Other mental illness Currently a problem? Yes No

**Who do you live with?** Name \_\_\_\_\_ Relationship to you? \_\_\_\_\_

**Supportive?** Yes No Among your friends and family who do you count on for support? \_\_\_\_\_

**Are you:** Single Married / Partnered Divorced Widowed

**Sexual Orientation:** Straight Lesbian Gay Bisexual Queer Uncertain

**If applicable, describe your relationship with your current partner by circling one of the below categories**

I'm pretty happy It's okay Minor Problems Major Problems Abusive

**How long have you been in the relationship?** \_\_\_\_\_

**Names and ages of children:** \_\_\_\_\_

**If applicable, do your children live with you?** Yes No

**How would you describe your relationship with your children?** Excellent Good Fair Poor

**Anything else you want me to know?** \_\_\_\_\_