Demographic Information

Name*: _____ _____ _____
(last) (first) (MI)

Pronouns: _____ Gender Identity: _____

Legal Name* (if different from above): _____

Racial Identity: _____ Ethnic Identity: _____

Birthdate*: _____/ _____/ _____
(month) (day) (year)

Contact Information

Phone Number*: _____
- ☐ Is it safe to leave a voicemail?
- ☐ Do you consent to receive texts?

Email address*: _____
- ☐ Do you consent to receive emails?

Emergency Contact

Name*: _____ Relationship*: _____

City: _____ State: _____

Phone Number*: _____ _____
(primary) (secondary)

____ (initials) I consent to have this person contacted in case of an emergency and allow my therapist to identify my name and relationship to them.

- ☐
- ☐

Getting Started Questionnaire

Please answer these questions to the best of your ability. If you don't know or have a question, we can discuss it in your appointment. Remember: any information you provide is considered confidential client information.

1. What brings you to counseling at this time? Is there something specific, such as a particular event? Be as detailed as you feel comfortable.

2. Have you ever seen a therapist or counselor before? ___ Yes ____ No
   If so, when did you last see them?

3. If you are taking any kind of medication, please describe what it is and what it is for. (put N/A if not applicable)

4. Do you drink alcohol? ____ Yes ____ No
   If so, what do you drink and how often?

5. Do you take any kind of recreational drugs (Weed, Molly, E, mushrooms, etc.)?
   If so, what do you take and how often?

6. Do you ever think about killing yourself? ___ Yes ___ No
   If so, what do you think about and how often?

7. Have you ever tried to kill yourself? ____ Yes ____No

If so, when did you try and how?

8. Do you ever think about wanting to hurt other people or animals? ____ Yes ___ No
   If so, what do you think about and how often?

9. Does anyone else in your family struggle with their mental health? ____ Yes ___No

10. What grade are you in and what school do you attend?

11. Please check any of the following you have experienced in the last 6 months.

	Increased appetite		Decreased appetite
	Trouble concentrating		Difficulty sleeping
	Excessive sleeping		Low or no motivation
	Isolation from others		Fatigue/low energy
	Low self-esteem		Depressed mood
	Tearful or crying more often		Anxiety
	Fear		Hopelessness
	Panic		Other:

☐
☐

12. Please check any of the following that apply to your physical health:

	Headache		High blood pressure
	Stomach issues		Hormone related problems
	Head injury		Chest pain
	Chronic pain		Loss of consciousness
	Heart attack		Bone or joint problems
	Seizures		Kidney issues
	Chronic fatigue		Heart problems
	Numbness and Tingling		Shortness of breath
	Diabetes		Hepatitis
	Asthma		Arthritis
	Thyroid issues		HIV/AIDs
	Sexually Transmitted Infection		Cancer
	Other		

13. What else would you like me to know?