Lowry Hill Psychotherapy & Assessment Center

To assist in helping you, please fill out this form as fully and openly as possible. All private information is held in the strictest confidence within legal limits.

Personal Information

Name:_____Today's Date:_____

Guardian's Name _____

Age: _____ Date of Birth:_____Telephone:_____

Address:_____

Gender: Male____ Female ____ Transgender: MtF____ FtM_____ Other: _____

Sexual Orientation:

_____ Asexual
_____ Bisexual
_____ Gay
_____ Heterosexual
_____ Lesbian
_____ Pansexual
_____ Queer
_____ Questioning

Race/Ethnic Origin:

_____ Black/African American: _____
_____ Asian/Pacific Islander: _____
_____ White/Caucasian: _____
_____ Hispanic/Latina(o): _____
_____ Native American: _____
_____ Other (specify): _____

Presenting Problem

What are your main reasons for coming to counseling?_____

_____

_____

How have you attempted to cope with your problems? _____

_____

_____

Under what conditions do your problems usually get worse?_____

_____

Under what conditions do your problems usually get better?_____

_____

How long has this problem persisted?_____

Counseling History

Have you received counseling in the past? Yes___ No___

Previous Treatment: (psychiatry, therapy, in home services, day treatment, residential)
Name/Setting: Dates: Reason:

_____
_____
_____

Psychiatric Hospital Admissions:
Name/Setting: Dates: Reason:

_____
_____
_____

History of Suicide ideation or attempts? Yes_____No_____ Describe_____
_____

Past Diagnosis:

_____ ADHD
_____Anxiety
_____Bi-Polar Disorder
_____BPD
_____ Depression
_____ Developmental Disorders
_____ Learning Disabilities
_____ Mood Disorders
_____ OCD
_____ ODD/ Conduct
_____ Personality Disorder
_____ Psychotic Disorders
_____ PTSD
_____ Reactive Attachment Disorder
_____ Self Harm
_____ Other:_____

Medical History

Physician(s)/Psychiatrist(s) contact information:
Name:_____
Address:_____
Phone Number:_____

List any physical concerns that you are presently having: (e.g. high blood pressure, headaches, dizziness. etc.)_____
_____

List any physical concerns/chronic conditions that you have experienced in the past:_____
_____

List any major illnesses and/or operations that you have had:_____
_____

Any In utero or Birth Related Trauma? Yes___ No____ Describe_____
_____

When was your last complete physical exam?_____
Are you sexually active? Yes___ No____
Do you have any intimacy related concerns? Yes___ No____

How many hours of sleep do you get per day?_____

Do you have trouble: falling asleep? Yes____ No____ staying asleep? Yes____ No____

Have you gained or lost (please circle) over ten pounds in the past year? Yes____ No____

Describe your appetite: Poor____ Average____ High____

What medications are you taking (please provide dosage and frequency), and for what purpose?

_____

_____

_____

Personal History

Work/ Education:

Current Occupation:_____

Any current/ past issues related to keeping employment? Yes_____ No_____
Describe_____

_____

List your main difficulties at work: _____
_____
_____

Highest Level of Education:_____

History of Difficulty in School? Yes_____ No_____ Describe_____

_____

Home:

Who do you currently live with? (e.g. roommate, partner, etc.)_____

_____

Any Current Housing or financial concerns? Yes____No_____

Describe any difficulties/concerns at home: _____

_____

_____

Adverse History Related to Housing? (e.g. large number of moves, homelessness)
Yes____No_____Describe_____

Relationships:

Current Relational status: (check all that apply)
_____Single _____Dating _____Partnered _____Married
_____Separated _____Divorced _____Widowed Other_____
Length of relationship with current partner? _____

History of Relationship Difficulties? Yes____No_____ Describe_____

_____

_____

List your main social difficulties: _____

_____

_____

List your main love and sex difficulties: _____

_____

_____

Other:
Legal History? Yes____No_____ Describe_____

_____

Concerns related to Addictive Behavior? Yes____No_____ Describe_____

_____

Spirituality/ Religion:

Are you religious/spiritual? Yes____ No____ If yes, what faith?_____

How important is your faith to you?
Not Important Average Importance Extremely Important
1 2 3 4 5 6 7 8 9 10

History of a religious background? Yes____No_____ Describe_____
_____

Is there anything about your identity, spiritual/religious beliefs, or other factors that would be helpful for your therapist to know? Please specify: _____
_____

History related to trauma:

Have you ever experienced?

Emotional abuse	Yes____No_____
Sexual Abuse	Yes____No_____
Physical Abuse	Yes____No_____
Neglect	Yes____No_____
Witnessing Domestic Violence	Yes____No_____
Community violence	Yes____No_____
Being accused of being emotionally abusive	Yes____No_____
Being accused of sexually abusing another	Yes____No_____
Being accused of physically abusing another	Yes____No_____

Other trauma history, Describe_____

Family History

Your Place of Birth:_____
Mother's Age:_____ If deceased, how old were you when she died?_____

Father's Age:_____ If deceased, how old were you when he died?_____

Step Mother's Age:_____ Step Father's Age:_____If deceased, how old were you when s/he died?_____

Other Guardian's Name/Relation/Age:_____
If deceased, how old were you when s/he died?_____

If your parents are separated/divorced, how old were you when this occurred?_____

Were you adopted or raised by someone other than your birth parents? Yes___ No___

Family Mental Health History (include relationship to you)

☐ADHD	☐Bulimia/Anorexia	☐Personality Disorder	☐Unknown
☐Anxiety	☐Depression	☐Schizophrenia	
☐Bipolar	☐OCD	☐Other _____	

Family History of Chemical Abuse/Dependency (current/ historic)

☐Father ☐Mother ☐Brother ☐Grandparent

☐Uncle ☐Aunt ☐Unknown ☐Other _____

History of Family Members experiencing Abuse/ neglect (current/ historic)

☐Father ☐Mother ☐Brother ☐Grandparent

☐Uncle ☐Aunt ☐Unknown ☐Other _____

Siblings:

Number of Brothers:_____ Names/Ages:_____

Number of Sisters:_____ Names/Ages:_____

Number of Step or Half Brothers:_____Names/Ages:_____

Number of Step or Half Sisters:_____ Names/Ages:_____

I was child number_____ in a family of _____ children.

Briefly describe your relationship with you siblings:_____

_____

_____

Which of the following best describes the family in which you grew up?

Warm & Accepting Average Hostile & Fighting

1 2 3 4 5 6 7 8 9 10

Which of the following best describes the way in which your family raise you?

Allowed me to be independent Average Attempted to Control Me

1 2 3 4 5 6 7 8 9 10

Your Mother (or mother substitute):

Briefly describe your mother:_____

_____

_____

How did she discipline you?_____

_____

How did she reward you?_____

_____

How much time did she spend with you as a child? A lot____ Average____ Very Little____

Mother's occupation when you were a child:_____

_____stayed home full time _____ worked outside part-time _____ worked outside full time

How did you get along with your mother as a child? ___ poorly ___ average ___ well
How do you get along with your mother now? ___ poorly ___ average ___ well
Did your mother have any problems (e.g. alcoholism, violence, etc.) that may have affected your development? Yes____ No____ If yes, please describe:_____
_____

Describe overall how your mother treated the following people as you were growing up:

	Poor				Average					Excellent
You	1	2	3	4	5	6	7	8	9	10
Your Family	1	2	3	4	5	6	7	8	9	10
Your Father	1	2	3	4	5	6	7	8	9	10

<u>You Father (or father substitute)</u>:
Briefly describe your father:_____
_____
_____

How did he discipline you?_____
_____

How did he reward you?_____
_____

How much time did he spend with you as a child? A lot____ Average____ Very Little____

Father's occupation when you were a child:_____
_____stayed home full time _____ worked outside part-time _____ worked outside full time

How did you get along with your father as a child? ___ poorly ___ average ___ well
How do you get along with your father now? ___ poorly ___ average ___ well
Did your father have any problems (e.g. alcoholism, violence, etc.) that may have affected your development? Yes____ No____ If yes, please describe:_____
_____

Describe overall how your father treated the following people as you were growing up:

	Poor				Average					Excellent
You	1	2	3	4	5	6	7	8	9	10
Your Family	1	2	3	4	5	6	7	8	9	10
Your Mother	1	2	3	4	5	6	7	8	9	10

Substance Use History

Substance Use:

Caffeine:	Current ____	Past____	Age started_____	Amount_____
Nicotine:	Current ____	Past____	Age started_____	Amount_____
Alcohol:	Current ____	Past____	Age started_____	Amount_____
Marijuana:	Current ____	Past____	Age started_____	Amount_____
Cocaine:	Current ____	Past____	Age started_____	Amount_____
Methamphetamine:	Current ____	Past____	Age started_____	Amount_____
Opiods/ Heroin:	Current ____	Past____	Age started_____	Amount_____
Hallucinogens:	Current ____	Past____	Age started_____	Amount_____
Pain medications (nonprescribed amount):	Current ____	Past____	Age started_____	Amount_____
Benzodiazepines (nonprescribed amount):	Current ____	Past____	Age started_____	Amount_____
Stimulants (nonprescribed amount):	Current ____	Past____	Age started_____	Amount_____

CAGE aid:

Do you lie or conceal how much you drink/use drugs? _____ Yes _____ No

Do you miss work/class or other responsibilities because you are under the influence or recovering from consuming alcohol/drugs? _____ Yes _____ No

In the past month, have you used any drugs not prescribed for you? _____ Yes _____ No

Have you ever decided to stop drinking/using drugs but found that for some reason you didn't do it? _____ Yes _____ No

Have you ever faced any judicial or legal consequences for your drinking/drug use? _____ Yes _____ No

Have you ever lost friends because of your drinking/drug use? _____ Yes _____ No

Have you ever felt you should cut down on your drinking or drug use?
Drinking: YES____ NO____ Drug Use: YES____ NO____

Have people annoyed you by criticizing your drinking or drug use? Drinking: YES____ NO____ Drug Use: YES____ NO____

Have you ever felt bad or guilty about your drinking or drug use? Drinking: YES____NO____ Drug Use: YES____NO____

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)?
Drinking: YES____NO____ Drug Use: YES____ NO____

Self Symptom Assessment

List Your 5 greatest strengths:

1) _____
2) _____
3) _____
4) _____
5) _____

Please check how often the following thoughts occur to you:

Life is hopeless	____Never	____Rarely	____Sometimes	____Frequently
I am lonely	____Never	____Rarely	____Sometimes	____Frequently
No one cares about me	____Never	____Rarely	____Sometimes	____Frequently
I am a failure	____Never	____Rarely	____Sometimes	____Frequently
Most people don't like me	____Never	____Rarely	____Sometimes	____Frequently
I want to die	____Never	____Rarely	____Sometimes	____Frequently
I want to hurt myself	____Never	____Rarely	____Sometimes	____Frequently
I want to hurt someone else	____Never	____Rarely	____Sometimes	____Frequently
I am stupid	____Never	____Rarely	____Sometimes	____Frequently
I am going crazy	____Never	____Rarely	____Sometimes	____Frequently
I can't concentrate	____Never	____Rarely	____Sometimes	____Frequently
I am so depressed	____Never	____Rarely	____Sometimes	____Frequently
I can't be forgiven	____Never	____Rarely	____Sometimes	____Frequently
Why am I so different?	____Never	____Rarely	____Sometimes	____Frequently
I can't do anything right	____Never	____Rarely	____Sometimes	____Frequently
People hear my thoughts	____Never	____Rarely	____Sometimes	____Frequently
I have no emotions	____Never	____Rarely	____Sometimes	____Frequently
Someone is watching me	____Never	____Rarely	____Sometimes	____Frequently
I hear voices in my Head	____Never	____Rarely	____Sometimes	____Frequently
I am out of control	____Never	____Rarely	____Sometimes	____Frequently

Please check the symptoms that occur more often than you would like:

____ aggression	____ drug dependence	____memory impairment	____weight changes
____ alcohol dependence	____ eating disorder	____mood shifts	____perfectionism
____ anger	____ fatigue	____panic attacks	____nightmares
____ antisocial behavior	____ hallucinations	____phobias/fears	____low energy
____ anxiety	____ heart racing	____difficulty concentrating	____self-harming
____ avoiding people	____ high blood pressure	____sexual difficulties	____feeling inferior
____ chest pain	____ hopelessness	____lack of social support	____sick often
____ depression	____ impulsiveness	____sleeping problems	____work problems
____ disorientation	____ irritability	____suicidal thoughts	____rape/sexual abuse
____ distractibility	____ judgment errors	____thoughts disorganized	____domestic abuse
____ dizziness	____ loneliness	____trembling	____ inattention
____withdrawing	____worrying	____ other (specify below)	

Please include any additional information that you think would be helpful: _____

_____

_____

_____

_____

_____

_____