New Beginnings Counseling LCSW P.C.

Purpose of visit:

_____

_____

_____

What would you like to accomplish out of your time in therapy? _____

_____

_____

Referral Source:_____

Highest level of education:_____

Profession:_____

Are you currently experiencing any chronic pain? □ No □ Yes

If yes explain:_____

Are you currently experiencing sadness or depression? □ No □ Yes

Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes

If yes, explain:_____

Are you currently experiencing grief or loss? □ No □ Yes

If yes, explain:_____

Exercise Regimen: Y___/____N, explain:

_____

Please describe any difficulties you experience with your appetite or eating problems:

_____

If there are no issues with appetite or eating skip questions a-e.

a. Do you make yourself Sick because you feel uncomfortably full? ___Y/N____
b. Do you worry that you have lost Control over how much you eat?___ Y/___N
c. Have you recently lost more than 14 pounds in a 3-month period? __Y/__N
d. Do you believe yourself to be fat when others say you are too thin? ___Y/___N
e. Would you say that food dominates your life? ___Y/___N

Sleep Hygiene, how many hours of sleep do you get nightly? _____

History of physical trauma such as car accident, concussion/contusion: ____ Yes/____No.

History of domestic violence: __ Y/___N Currently: ___Y/___N
Explain:_____

History of sexual abuse:__Y/___N

In the last five years any involvement with child welfare or foster care? Y___/N___
Explain:_____

History of any type of self-mutilation or cutting: ___Y/___N Explain:

History of attempted suicide? ___Y/____N How many times:_____/n/a_____ Dates: _____
Explain:_____
_____

Are you on probation or parole?___ Y/___N If yes,
explain:_____

Do you use an electronic vape: ___Y/N___

Do you smoke cigarettes? ___Y/___N How many cigarettes do you smoke daily?_____ Have you thought about quitting in the past three months? ___Y/___N

Do you currently consume alcohol: ___Y/____N

If yes, alcohol consumption circle one: Daily/weekly/monthly. How many drinks per occasion to you consume? ____ Y/N. Last use of alcohol_____/n/a_____.

Do you use illegal drugs? __Y/___N. If yes list drug(s):_____
Frequency:_____

Do you use marijuana? ___Y/___N Frequency: _____Last use:_____

Do you have a medical marijuana card?___Y/N____

Name and phone number of treating doctor:_____

Current/history treatment for substance use including alcohol? Yes/No, Where/date: _____
_____
_____

Current time spent on social media such as FaceBook, Instagram, Twitter etc._____/n/a_____

Do you gamble?___Y/___N *If you answer no skip questions 1-3.

1. During the past 12 months, have you become restless irritable or anxious when trying to stop/cut down on gambling? __Yes __ No

2. During the past 12 months, have you tried to keep your family or friends from knowing how much you gambled? __Yes __ No

3. During the past 12 months did you have such financial trouble as a result of your gambling that you had to get help with living expenses from family, friends or welfare? __ Yes __No

Patient Signature:_____ Date:_____