THERAPY STUDIOS

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INDIVIDUAL INQUIRY.....PAGE 1 OF 5

NAME_____TODAYS DATE_____
EMAIL ADDRESS_____PHONE # _____
DATE OF BIRTH_____CURRENT AGE____ PARTNERSHIP STATUS_____
CURRENT GENDER_____
GENDER ASSIGNED AT BIRTH_____
EMERGENCY CONTACT + PHONE #_____
_____

PEOPLE IN YOUR CARE (ie, children, elderly persons, differently abled persons)
_____
_____

OCCUPATION & EMPLOYER _____
_____

EDUCATION LEVEL/ DEGREES HELD_____
_____

CURRENTLY IN SCHOOL? If so, what school do you attend?_____
_____

CURRENTLY INVOLVED IN ANY COURT PROCEEDINGS?_____
PRIMARY REASON FOR SEEKING THERAPY_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

GOALS FOR THERAPY_____
_____
_____
_____
_____
_____

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INDIVIDUAL INQUIRY.....PAGE 2 OF 5

CURRENT MEDICAL CONCERNS (Please note treating Practitioner for each ailment)

_____

_____

_____

_____

CURRENT MEDICATIONS & SUPPLEMENTS

Name of Medication/Supplement	Dosage	Used for

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Have you had prior psychotherapy/counseling experience? If yes, was it helpful?

_____

_____

_____

Have you ever been hospitalized for a psychological reason, such as suicidal ideation, psychosis, suicidal attempt or substance treatment? If yes, please list instances, dates, and a brief description::: _____

_____

_____

_____

Have you ever been hospitalized for a non-psychological reason such as accidents, physical injury, physical illness? Please list instances, dates, and a brief description:::

_____

_____

_____

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INDIVIDUAL INQUIRY……PAGE 3 OF 5

EXERCISE & PHYSICAL FITNESS PRACTICES:::_____

_____

_____

KNOWN ALLERGIES:::_____

_____

DESCRIBE YOUR SLEEP IN THE PAST TWO WEEKS:::_____

_____

_____

DESCRIBE YOUR DAILY DIET IN THE PAST TWO WEEKS:::_____

_____

_____

Do you have any family history of mental illness? If yes, please list who had the illness, their relationship to you, and for how long they have experience(ed) the illness(es):::

_____

_____

_____

_____

_____

Has anyone in your family died earlier than expected? If so, who was it, how are they related to you, and how did they pass? _____

_____

_____

_____

Please circle if you have ever used the following:::

ALCOHOL CANNABIS COCAINE CRACK METH HALLUCINOGENS HEROIN MDMA/ECSTASY OTHER

Please circle if you have CURRENTLY used the following

ALCOHOL CANNABIS COCAINE CRACK METH HALLUCINOGENS HEROIN MDMA/ECSTASY OTHER

_____

Have you ever had hallucinations without being under the influence of substances?

_____

_____

Have you ever had thoughts of hurting yourself or ending your life? _____

Do you currently have thoughts of hurting yourself?_____

Do you currently have thoughts of ending your life?_____

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INDIVIDUAL INQUIRY.....PAGE 4 OF 5

PLEASE LIST THE MEMBERS OF YOUR FAMILY OF ORIGIN + CHOSEN FAMILY

NAME AGE RELATIONSHIP QUALITY, CHILDHOOD RELATIONSHIP QUALITY, NOW

PARTNER _____

BEST FRIEND _____

MOTHER _____

FATHER _____

STEPMOTHER _____

STEPFATHER _____

SIBLING _____

SIBLING _____

SIBLING _____

SIBLING _____

SIBLING _____

SIBLING _____

SIBLING _____

CHILD/STEPCHILD _____

CHILD/STEPCHILD _____

CHILD/STEPCHILD _____

CHILD/STEPCHILD _____

CHILD/STEPCHILD _____

_____

_____

Were you ever abused as a child? If so, please briefly describe & indicate if it was verbal/sexual/emotional/physical_____

_____

_____

Have you ever been abused as an adult? If so, please briefly describe & indicate if it was verbal/sexual/emotional/physical_____

_____

_____

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INDIVIDUAL INQUIRY.....PAGE 5 OF 5

What is a most difficult situation you have faced in life & what helped you through it?

RELIGIOUS & SPIRITUAL PRACTICES

What is your proudest moment in life? Why is this your proudest moment?

Please list 4 things you like the most about yourself (feel free to add more than 4).

What are you hoping to get out of therapy?

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