Gemma Utting, MA, LMFT, CLC

Today's Date ___________________

Overview & Contact Information

Given Name _____________________ Family Name _______________________

Date of Birth: (month) ___________________ (day) ______ (year) ________

Best Contact Phone # ____
May I leave you a confidential message on this phone? Yes / No

Best Contact Email ____
May I leave you a confidential message via Email? Yes / No

Mailing Address ____

In Case of Emergency, whom should I contact?

Print Name ____

Phone #: _________________________ Relationship ______________________

Work
Where do you work? ____

What is your role at work? ____

How long have you worked here? ___________ What education / training have you had for this position? ____

What do you really wish you could do (!) ________________________________

Family
Name of your spouse/partner ____

Age? ______ Length of Relationship? _____________

List first names and ages of children living in the home:
(Name) _______________________ (Age) ______ (Issues?) Yes ___ / No ____

(Name) _______________________ (Age) ______ (Issues?) Yes ___ / No ____

(Name) _______________________ (Age) ______ (Issues?) Yes ___ / No ____

(Name) _______________________ (Age) ______ (Issues?) Yes ___ / No ____

Do you have other children living with a different parent or out of the home?

(Name) _______________________ (Age) ______ (Issues?) Yes ___ / No ____

(Name) _______________________ (Age) ______ (Issues?) Yes ___ / No ____

(Name) _______________________ (Age) ______ (Issues?) Yes ___ / No ____

Physical Health
Primary Physician ___________________________ Phone ______________

How would you rate your physical health? (Circle one from each group)
(Circle one) Excellent / Good / Fair / Poor (Circle one) Improving / Worsening

Please list any physical or medical concerns you have: (Circle One Below)

(Issue) ______________________________(Treatment?) Yes/No/Needed
(Issue) ______________________________(Treatment?) Yes/No/Needed
(Issue) ______________________________(Treatment?) Yes/No/Needed
(Issue) ______________________________(Treatment?) Yes/No/Needed

Has your appetite increased, decreased or stayed the same over past 3 months?

____

Have you gained or lost weight recently? Yes/No How much? ______________

How often do you have difficulty falling asleep? ______________________

How often do you wake up in the night and have trouble falling back to

sleep? ____

Medications
Please list all the over-the-counter medications you are taking:

Drug	**Strength**	**Daily Dose**	**How Long?**

Please list all prescription medications you are taking:

Drug	**Strength**	**Daily Dose**	**How Long?**

Name of prescribing doctor (if not your Primary Care Physician)

Psychiatrist _______________________________ Phone ______________

Addictions

Item	*Quantity*	*Current Problem?*	*Past Problem?*
Cigarettes		Yes / No	Yes / No
Alcohol		Yes / No	Yes / No
Prescription Drugs		Yes / No	Yes / No
Illegal Drugs		Yes / No	Yes / No
Porn		Yes / No	Yes / No

Depression / Suicide

Have you ever suffered from depression? Yes / No

If yes, please continue. If depression is an ongoing problem for you how long has this been the case? ____________ weeks / months /years

If you are now depressed, but this is not usual for you, how long have you felt this way? ____________ days / weeks / months

Have you recently thought about killing yourself? Yes / No
If yes, do you have a plan? Yes / No
If you have a plan, do you have what you need to carry it out? Yes / No
Have you ever attempted suicide before? Yes / No

Relationships

Are you experiencing abuse in any of your current relationships? Yes / No
If yes please continue: The abuse is (check all that apply)
____ Physical ____ Emotional ____ Sexual

Have you ever experienced abuse in your past relationships? Yes / No
If yes please continue: The abuse was (check all that apply)
____ Physical ____ Emotional ____ Sexual

Current Concerns

In your opinion, could you please tell me ~

What is bringing you into therapy right now – what's upsetting you?
____
____
____
____

What do you think is causing this problem / problems?
____
____
____
____

What have you already tried to do to improve things?
____
____
____
____

What do you think needs to happen to improve things now?
____
____
____
____