Demographics & Self-Assessment Form

Name (Include preferred name as well):

_____

Today's Date: _____
Name of person filling out this form (if not client): _____
Full Local Address:

_____

_____

Sexual & Gender Identity: _____

Race/Ethnic Identity: _____

Name of Primary Care Physician:

_____

Date of Birth: _____ Age: _____

Phone (best number(s) to reach you): _____
Is it OK to leave messages at this number? Y / N
Preferred Email Address:

_____
Is it OK to email you? Y / N
*Please be aware that email may not be confidential

Name, number and full address of person to call in case of emergency:

_____

_____

_____

Relationship to emergency contact above:

_____
*I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I can do so:

_____

Marital Status: Single / Never Married / Committed Relationship / Engaged / Married / Separated / Divorced / Widowed / Living Cooperatively / Marriage Annulled (Circle One)

Years Married: _____ Years Divorced: _____ Length of Separation: _____

Spouse Name: _____ Age: _____

Occupation: _____

Number of Children: _____

Education:

- ❏ High school or earlier
- ❏ College or University
- ❏ Post-Graduate

Occupation or School Name (and location):

_____

If utilizing insurance to assist with payment for services, please include the following information:

Insurance Plan: _____ Member ID Number: _____

Group Number: _____

Referred by: _____

*Do I have permission to thank this person for the referral?

Please describe the reason for you are seeking psychotherapy at this time:

_____

_____

_____

_____

What are your goals for treatment?

_____

_____

_____

Please describe your symptoms from the time they started to the present:

_____

_____

_____

_____

_____

_____

_____

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? Y / N. Please describe these services:

_____

_____

_____

Have you had previous psychotherapy? Y / N, at previous therapist's name:

_____

_____

_____

_____

_____

Are you currently taking prescribed psychiatric medications? (antidepressants, anti-anxiety or others?) Y / N. Please list and describe your response to them.

_____

_____

_____

If no, have you previously been prescribed psychiatric medication? Y / N. Please list and describe your response to them.

_____

_____

_____

What are your goals for therapy?

_____

_____

_____

Suicide:

- ❏ I have never thought about suicide.
- ❏ I have thought about suicide in the past.
- ❏ I have attempted suicide in the past.
- ❏ I am having thoughts of suicide right now.

Please describe any and all thoughts of suicide (If you checked any of the boxes above other than “I have never thought about suicide,” please write when was the last time and how?):

_____

_____

_____

Harm to Others:

- ❏ I have never thought about harming someone else.
- ❏ I have thought about harming someone else.

Please describe any and all thoughts of harming someone else (If you checked “I have thought about harming someone else,” please write when was the last time, and how?):

_____

_____

_____

How is your physical health at this time?

- ❏ Poor
- ❏ Unsatisfactory
- ❏ Satisfactory
- ❏ Good
- ❏ Very Good

Do you smoke? Y / N. How much and for how long?

_____

_____

Do you drink caffeine (coffee, tea or soda)? Y / N. How much?

_____

_____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

_____

_____

_____

_____

Please list any medications you are using to address above health concerns:

_____

_____

_____

Please list any past surgeries or accidents and age they happened:

_____

_____

Are you having any problems with sleep habits? Y / N. If yes, mark where applicable below:

- ❏ Sleeping too little
- ❏ Sleeping too much
- ❏ Poor quality
- ❏ Disturbing dreams, Sleepwalking, Other Difficulties

Are you having difficulty with appetite or eating habits? Y / N. If yes, mark where applicable below:

- ❏ Eating less
- ❏ Eating more
- ❏ Binge eating
- ❏ Restricting my eating
- ❏ Purging

Have you experienced significant weight loss in the last 5 years? Y / N. Please describe any increase or decrease in weight over the past 5 years:

_____

_____

_____

Do you regularly use alcohol? Y / N.

How many drinks do you consume in the average day?

- ❏ None
- ❏ 1-2
- ❏ 2-3
- ❏ 3-4
- ❏ 4-5
- ❏ 5 or more

What time of day do you normally consume alcohol?

- ❏ Early Morning
- ❏ Mid Morning
- ❏ Early Afternoon
- ❏ Mid Afternoon
- ❏ Evening
- ❏ After 10:00pm

Have you, or someone else, thought that you were drinking too much? Y / N. Please describe:

_____

_____

_____

Have you ever taken any of the following drugs?

- ❏ Marijuana
- ❏ Amphetamines/Speed
- ❏ Heroin/Opiates
- ❏ PCP
- ❏ LSD, Mushrooms, or other hallucinogens
- ❏ Cocaine/Crack
- ❏ Barbiturates/Sedatives/Downers
- ❏ Pain Killers
- ❏ Any medication not prescribed to you

If you checked any drug above, what circumstances did you take this/these drugs under? Please describe and include last use:

_____

_____

_____

_____

When did you most heavily use drugs or alcohol? Please describe:

_____

_____

_____

Has anyone in your family (immediate family members or relatives) experienced difficulties with depression or anxiety? Has anyone experienced any traumas or alcohol/substance abuse?

_____

_____

_____

Have you experienced any significant traumas in your childhood? Please list and describe:

_____

_____

_____

_____

Are your parents still married? Y / N. If they divorced, how old were you when they separated or divorced? _____

Were there any other primary caregivers you had a significant relationship with? If so, please describe how this relationship impacted you?

_____

_____

_____

Mother's age and occupation (If deceased, age of death):

_____

Father's age and occupation (If deceased, age of death):

_____

How many brothers do you have? _____ What are their ages? _____

How many sisters do you have? _____ What are their ages? _____

How would you describe your relationships with your siblings?

_____

_____

_____

Are you currently in a romantic partnership? Y / N. For how long? _____

Is spirituality important in your life? Y / N. If so, please describe:

_____

_____

_____

Please provide any additional information you think it would be important for Dr. Abrams to know:

_____

_____

_____

_____

_____

_____

_____

Signature:

_____