Center for Relationship and Sexual Wellness, PLLC
Heather Guttormson, MS LMFT, CAST-C

Full Name:

DOB:

Address:

City: State: Zip:

Contact Numbers	May we contact you at this number?	May we leave a message?
Home:		
Work:		
Cell:		

Emergency Contact

Name Phone number

Relationship

How did you hear about us and/or who referred you?

Please list your immediate family members

Name Relationship

Please list all children and/or dependents

Name Age Relationship

What is your current marital status?

Married Never married and in a long term relationship Single

Divorced Separated Widowed

How many times have you been married?

What was the cause of your prior relationship(s) ending?

How long have you been in your current relationship?

Please describe your current living situation:

Education
Highest level of education completed:
When did you graduate?
Have you ever been diagnosed with a learning disability including ADHD?
If yes, please explain:

Have you ever struggled with any mental health issue prior to this date such as depression or anxiety?
Please explain.

Have you received or are your receiving medication for any mental health issue? If yes, please list.

Have you ever been in counseling before? If yes, for what was the issue you worked on and when?

Are you currently employed?
How long have you been in your current position?

Have you ever served in the military? Please describe your service.

Do you identify with any spiritual or religious beliefs?

How do you practice these beliefs?

How would you like these beliefs integrated into your treatment?

Please list any current medical issues:

Please list any past medical issues:

Please list all medications you are currently prescribed

Name	Use	Dosage

Primary Medical Provider

Provider's Network:

Are you currently involved in the legal system or in the last do you have a history of legal involvement?
Please describe.

To the best of your knowledge, what were the conditions of your birth? (premature, healthy full-term, complications).

To the best of your knowledge, did you mother use cigarettes, alcohol, abuse prescription drugs or use any illegal substances during the pregnancy? If yes, please list.

Do you have any history of abuse? Please list age and any other information you feel comfortable sharing.

Physical

Emotional

Sexual

Please discuss your current concern(s) that brought you in today:

What are your goals for therapy?

Please list any additional information that may be important for your therapist to know:

PATIENT NAME: _____ DATE: _____

PHQ-9

	Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
		PHQ9 total score:			

Q6 CORE10	I made plans to end my life in the last 2 weeks	NO	YES

GAD-7

	Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3
		GAD7 total score:			