LAROSA COUNSELING

PLLC

| | |
|---|---|
| Name: | |
| Date of Birth: | |
| Address: | |
| Phone Number: | |
| Email: | |

**What brings you in today?**

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**Please rate the following symptoms based on how this applies to your personal experiences:**

**0 = not present, 1 = mild, 2 = moderate, 3 = severe**

| | | | | |
|---|---|---|---|---|
| **Depression** | ☐ **0** | ☐ **1** | ☐ **2** | ☐ **3** |

| | | | | |
|---|---|---|---|---|
| **Anxiety** | ☐ **0** | ☐ **1** | ☐ **2** | ☐ **3** |
| **Mood Swings** | ☐ **0** | ☐ **1** | ☐ **2** | ☐ **3** |
| **Appetite Changes** | ☐ **0** | ☐ **1** | ☐ **2** | ☐ **3** |
| **Sleep Changes** | ☐ **0** | ☐ **1** | ☐ **2** | ☐ **3** |
| **Hallucinations** | ☐ **0** | ☐ **1** | ☐ **2** | ☐ **3** |
| **Work Problems** | ☐ **0** | ☐ **1** | ☐ **2** | ☐ **3** |
| **Racing Thoughts** | ☐ **0** | ☐ **1** | ☐ **2** | ☐ **3** |
| **Confusion** | ☐ **0** | ☐ **1** | ☐ **2** | ☐ **3** |
| **Memory Problems** | ☐ **0** | ☐ **1** | ☐ **2** | ☐ **3** |
| **Loss of Interest** | ☐ **0** | ☐ **1** | ☐ **2** | ☐ **3** |
| **Irritability** | ☐ **0** | ☐ **1** | ☐ **2** | ☐ **3** |
| **Excessive Worry** | ☐ **0** | ☐ **1** | ☐ **2** | ☐ **3** |

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|---|---|---|---|---|
| **Suicidal Ideation** | ☐ **0** | ☐ **1** | ☐ **2** | ☐ **3** |
| **Relationship Issues** | ☐ **0** | ☐ **1** | ☐ **2** | ☐ **3** |
| **Low Energy** | ☐ **0** | ☐ **1** | ☐ **2** | ☐ **3** |
| **Panic Attacks** | ☐ **0** | ☐ **1** | ☐ **2** | ☐ **3** |
| **Obsessive Thoughts** | ☐ **0** | ☐ **1** | ☐ **2** | ☐ **3** |
| **Ritualistic Behavior** | ☐ **0** | ☐ **1** | ☐ **2** | ☐ **3** |
| **Checking** | ☐ **0** | ☐ **1** | ☐ **2** | ☐ **3** |
| **Counting** | ☐ **0** | ☐ **1** | ☐ **2** | ☐ **3** |
| **Self Injury** | ☐ **0** | ☐ **1** | ☐ **2** | ☐ **3** |
| **Difficulty Concentrating** | ☐ **0** | ☐ **1** | ☐ **2** | ☐ **3** |
| **Hyperactivity** | ☐ **0** | ☐ **1** | ☐ **2** | ☐ **3** |

**Have you sought mental health treatment before in the past? If yes, what were you being treated for?**

**When did your symptoms start?**

**Have you ever been admitted to a psychiatric hospital before?**

- ☐ Yes
- ☐ No

## III. Past Medical History

Please list any additional health information that may be important for you, therapist, to know (including any medication or other allergies or problems with pain):

**Do you use tobacco?**

- ☐ Yes
- ☐ No

**Do you drink alcohol?**

- ☐ Yes
- ☐ No

**If yes, how many drinks and how often?**

**Do you have a history of substance abuse?**

**Have you ever experienced any of the following?**

- ☐ Withdrawal symptoms such as: hallucinations, tremors, excessive seating, vomiting, seizures
- ☐ Blackouts
- ☐ Used illicit drugs or taken more medication than prescribed?
- ☐ None of the above

**Have you ever received treatment for substance abuse or utilized any recovery/support programs?**

**Have you experienced any legal issues related to the use of alcohol or other drugs?**

## VI. Family History

**How would you describe your current relationships with family?**

- ☐ Supportive/Close
- ☐ Distant/Estranged
- ☐ Unhealthy/Toxic
- ☐ Other:

**Is there any history of mental health or substance abuse problems in your family?**

**Are you:**

- ☐ Single
- ☐ In a relationship
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

**Do you regularly participate in social activities?**

- ☐ Yes
- ☐ No

**How would you describe your current support system?**

## VIII. Educational History

**What's your highest level of education?**

- ☐ Less than high school
- ☐ High School Diploma/GED
- ☐ Some College
- ☐ College Graduate
- ☐ Post Graduate Degree

**Did you experience any learning or behavioral issues in school?**

## IX. Work History

Do you currently work?

- ☐ Yes
- ☐ No

If yes, what is the name of your employer?

If yes, how long have you been working for your current employer?

## XI. Legal Status

- ☐ No legal problems
- ☐ Probation
- ☐ Jailed before
- ☐ Parole
- ☐ Charges pending
- ☐ Has a guardian

## XII. Sexuality

**What is your sexual orientation?**

- ☐ Heterosexual
- ☐ Homosexual
- ☐ Bisexual
- ☐ Other/Prefer not to answer

**What is your gender?**

- ☐ Male
- ☐ Female
- ☐ Non-binary
- ☐ Prefer not to answer

## XIII. Spirituality

Do you identify with any religion or spiritual system? If yes, what activities do you engage in?

## XIV. Cultural Background

**What race or ethnicity do you identify with?**

- ☐ White, Caucasian
- ☐ Asian
- ☐ Black, African American
- ☐ Hispanic, Latino, or Spanish origin
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Prefer not to answer

## XVI. Coping Skills and Mechanisms

What are current coping skills you use?

**What are the areas of concern that are a source of stress?**

- [ ] None
- [ ] Activities of daily living
- [ ] Work
- [ ] Finances
- [ ] School
- [ ] Family relationships
- [ ] Social relationships
- [ ] Safety
- [ ] Legal
- [ ] Cognitive functioning
- [ ] Physical health
- [ ] Housing
- [ ] Impulse control
- [ ] Social skills

**Is there anything else you feel I need to know that might be helpful for me to know?**

| Date: |
| --- |
| Signature: |