Samantha Davis, LMHC
499 Glen Street, Glens Falls, NY 12801
(518)798-9187

Please complete this form and bring it with you to your first session. The information provided on this form is confidential.

Personal Information

Name: _____ Date: _____

Date of Birth (dd/mm/yyyy): ____ /____ / _____

Parent/Legal Guardian (if under 18): _____

Address: _____

Phone Numbers: Home: _____ Cell: _____ Work:_____
May messages be left on your answering machine / voicemail? Yes_____ No_____

Marital Status:

☐ Married ☐ Never Married ☐ Domestic Partnership
☐ Separated ☐ Divorced ☐ Widowed

Referred By (if any): _____

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Address: _____

History

Have you ever received mental health services in the past? (psychotherapy, psychiatric services, inpatient mental health services / mental health hospitalization, etc.) ☐ Yes ☐ No
If yes, please describe:

_____

_____

Have you ever been diagnosed with a mental illness? ☐ Yes ☐ No
If yes, please describe:

_____

_____

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Has anyone in your family ever been diagnosed with a mental illness?

☐ Yes ☐ No

If yes, please describe:

_____

_____

Are you currently taking any prescription or over-the-counter medications?

☐ Yes ☐ No

If yes, please list:

_____

_____

Have you ever been prescribed psychiatric medication? ☐ Yes ☐ No

If yes, please list:

_____

_____

General and Physical Health Information

Do you have a Primary Care Physician? ☐ Yes ☐ No

If yes, please indicate name and address of provider:

_____

_____

Do you currently have any physical health issues? ☐ Yes ☐ No

If yes, please describe:

_____

_____

How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Excellent

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Are you currently experiencing any chronic pain? ☐ Yes ☐ No
If yes, please describe:

_____

_____

Do you use or have a history of alcohol or substance abuse? ☐ Yes ☐ No
If yes, please describe to the extent that you are willing:

_____

_____

Have you ever received any substance abuse counselling or services? (i.e. addictions treatment, rehabilitation, inpatient substance abuse treatment, etc.) ☐ Yes ☐ No
If yes, please describe:

_____

_____

Mental Health Information

Current Symptoms Checklist: (please check any symptoms that you are currently experiencing)

☐ Depressed mood	☐ Unable to enjoy activities	☐ Sleep pattern disturbance
☐ Loss of interest	☐ Concentration/forgetfulness	☐ Change in appetite
☐ Excessive guilt	☐ Fatigue	☐ Decreased Libido
☐ Racing thoughts	☐ Impulsivity	☐ Increased risky behavior
☐ Increased libido	☐ Decreased need for sleep	☐ Excessive energy
☐ Increased irritability	☐ Crying spells	☐ Excessive worry
☐ Anxiety attacks	☐ Avoidance	☐ _____
☐ Suspiciousness	☐ Hallucinations	☐ _____

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For any items checked, please indicate how these impact current functioning (i.e. relationships, employment, education, etc.):

What is/are the problem(s) for which you are seeking therapy?

Have you recently experienced any significant life changes or stressful events?

What are some of your strengths, skills, talents, etc.?

What do you consider to be some of your weaknesses, challenges, or barriers?

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Additional Information

Are you currently employed? ☐ Yes ☐ No

If yes, what is your current employment situation?

_____

_____

What is the highest level of education that you've completed? _____

Are you currently working towards furthering your education? ☐ Yes ☐ No

If yes, what is your area and level of study? _____

Do you have any religious or spiritual beliefs? ☐ Yes ☐ No

If yes, please describe your faith or beliefs.

_____

_____

What are some of your hobbies and interests?

_____

_____

What are you hoping to achieve from receiving therapy services? What goals do you have for your treatment?

_____

_____