Hope Dealers Worldwide

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Client Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):_____

Birth Date:_____/_____/_____ Age: _____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Never Married ☐Domestic Partnership ☐Married ☐ Separated ☐ Divorced ☐ Widowed

Please list any children/age: _____

Address: _____

_____ _____ _____
(City) (State) (Zip)

Home Phone: _____ May we leave a message? ☐ Yes ☐ No

Cell/Other Phone: _____ May we leave a message? ☐ Yes ☐ No

E-mail: _____ May we email you? ☐ Yes ☐ No

Emergency Contact:_____ Phone:_____

How were you referred to us: _____

Is there any additional information Hopedealers Worldwide should know about you:

_____

_____

_____

_____.

GENERAL HEALTH AND MENTAL HEALTH INFORMATION:

Have you previously received any type of mental health services (therapy, psychiatric services, etc.)? ☐ No ☐Yes,

If yes, previous therapist/practitioner(s): _____

Are you currently taking any prescription medication? □ Yes □ No
Please list:_____
_____

Have you ever been prescribed psychiatric medication? □ Yes □ No
If yes, Please list and provide dates: _____
_____

1. How would you rate your current physical health? (please circle)
   Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:
_____
_____

2. How would you rate your current sleeping habits? (please circle)
   Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:
_____
_____

3. How many times per week do you generally exercise? _____

   What types of exercise to you participate in? _____

4. Please list any difficulties you experience with your appetite or eating patterns:
_____

5. Are you currently experiencing overwhelming sadness, grief, or depression? ☐No ☐ Yes
   If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias? ☐ No ☐ Yes
   If yes, when did you begin experiencing this? _____

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

8. Do you drink alcohol more than once a week? ☐ No ☐ Yes

9. How often do you engage recreational drug use? ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

10. Are you currently in a romantic relationship? ☐No ☐ Yes If yes, for how long? _____
    On a scale of 1-10, how would you rate your relationship? And why? _____

11. What significant life changes or stressful events have you experienced recently: _____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	**Family Member**
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

1. Are you currently employed? ☐ No ☐ Yes If yes, what is your current employment situation?

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes
   If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

_____

_____

_____

_____

4. What do you consider to be some of your weaknesses?

_____

_____

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

_____

_____

Your signature below also indicates that you have read the Consent for Treatment and HIPPA agreement and agree to the terms.

PATIENT (or PARENTS/GUARDIANS, IF PATIENT IS A MINOR)

_____ _____

Signature of Patient or Parent(s)/Guardian(s) Date

_____ _____

Name of Patient or Parent(s)/Guardian(s) (Please print) Relationship(s) to Patient