

Present state of health: Poor Fair Good Excellent

Please list any medications you currently take (e.g., prescriptions, OTC medications, herbal/vitamin supplements):

Please list any significant medical history (e.g., surgeries, hospitalizations, diseases, conditions, etc.):

Please indicate if you have **ever** experienced:

- Abuse as a child
- Physical/Emotional abuse by a partner
- Sexual abuse/assault as an adult

Please indicate if you have **ever** had a problem with:

- Alcohol abuse
- Depression
- Eating disorder
- Drug abuse
- Anxiety
- Other: _____

Please check any of the following that are a **current** difficulty for you:

- | | | |
|--------------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Academic/work difficulties | <input type="checkbox"/> Emotional/verbal abuse | <input type="checkbox"/> Pregnancy concerns |
| <input type="checkbox"/> Alcohol/drug concerns (self) | <input type="checkbox"/> Family issues/parents/children | <input type="checkbox"/> Relationship concerns |
| <input type="checkbox"/> Alcohol/drug concerns (other) | <input type="checkbox"/> Finances | <input type="checkbox"/> Self-esteem/confidence |
| <input type="checkbox"/> Anger/irritability | <input type="checkbox"/> Friends | <input type="checkbox"/> Sexual concerns |
| <input type="checkbox"/> Anxiety/fear | <input type="checkbox"/> Gender identity | <input type="checkbox"/> Sexual abuse |
| <input type="checkbox"/> Assertiveness | <input type="checkbox"/> Grief/loss | <input type="checkbox"/> Sexual harassment |
| <input type="checkbox"/> Body image | <input type="checkbox"/> Identity development | <input type="checkbox"/> Sexual orientation |
| <input type="checkbox"/> Career decisions | <input type="checkbox"/> Legal matters | <input type="checkbox"/> Sleep disturbance/nightmares |
| <input type="checkbox"/> Concentration | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Cultural concerns | <input type="checkbox"/> Making decisions | <input type="checkbox"/> Suicidal thoughts/attempts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Parenting | <input type="checkbox"/> Unwanted sexual experience |
| <input type="checkbox"/> Disability concerns | <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Other (please specify): |
| <input type="checkbox"/> Eating/appetite concerns | <input type="checkbox"/> Physical complaints | |

In imminent danger situations, your therapist is required to act to ensure your safety. Providing an emergency contact person is in your best interest as a client, and you may do so below:

Emergency contact:

Name	Phone number	Relationship to you
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