CANALSIDE THERAPEUTIC ARTS

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Name: _____ Date: _____
What do you prefer to be called? _____

Name of Parent/Guardian (If under 18): _____

Birth Date: _____ Age: _____ Gender: ☐M ☐F

Marital Status:
☐Never Married ☐Partnered ☐Married ☐Separated ☐Divorced ☐Widowed

Number of Children: _____

Family Composition (Please list individuals residing in your home):
Name: Age: Relationship:

_____
_____
_____
_____
_____
_____

Local Address: _____
_____

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

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

Email: _____ May we email you? ☐Yes ☐No
**Please be aware that email my not be confidential.*

Referred by: _____

Are you currently receiving psychiatric services, professional counseling, or psychotherapy elsewhere?
☐Yes ☐No

Have you had previous psychotherapy? ☐Yes ☐No

Previous therapist's name? Dates:

_____
_____
(Names of therapists, dates, reason for leaving, progress made?)

Are you currently taking medication (antidepressants or others)?
☐Yes ☐No If yes, please list: _____
If no, have you previously been prescribed psychiatric medication?
☐Yes ☐No If yes, please list: _____

HEALTH & SOCIAL INFORMATION

How is your physical health at present?
☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Very Good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): _____

Name of Primary Care Physician _____ Phone # _____
Last Physical _____
Allergies _____

Are you having any problems with your sleep habits? ☐Yes ☐No
If yes, check where applicable:
☐Sleeping too much ☐Sleeping too little ☐Poor quality sleep ☐Disturbing dreams ☐Other

How many times per week do you exercise? _____ # of minutes? _____

Are you having any difficulty with appetite or eating habits? ☐Yes ☐No
If yes, check where applicable:
☐Eating less ☐Eating more ☐Binging ☐Purging ☐Restricting
Have you experienced significant weight changes in the last two months? ☐Yes ☐No

Do you regularly use alcohol? ☐Yes ☐No
Concerned about your use of alcohol or drugs? _____
Concerned about the use of alcohol or drugs by someone close to you? _____
How often do you engage in recreational drug use?
☐Daily ☐Weekly ☐Monthly ☐Rarely ☐Never

Have you had an unwanted sexual experience? ☐Yes ☐No
Have you experienced violence or had a traumatic experience? ☐Yes ☐No

Are you currently in a romantic relationship? ☐Yes ☐No
If yes, how long have you been in this relationship? _____
On a scale of 1-10, how would you rate the quality of your current relationship? _____

In the last year, have you experienced any significant life changes, or stressors?
☐Yes ☐No If yes, please list: _____

Please check any of the following problems which concern you: If you chack one, please describe in detail:

☐Depression
☐Motivation/Apathy/Energy/Fatigue
☐Rapid speech
☐Hallucinations
☐Unexplained memory lapse/time loss
☐Frequent body complaints
☐Homicidal thoughts
☐Repetitive thoughts (i.e. obsessions)
☐Sexual problems
☐Inferior feelings/Emptiness/Boredom
☐Shyness
☐Nightmares
☐Stomach issues/Health problems
☐Stress
☐Eating disorder/Appetite
☐Friends
☐Mood shifts
☐Anxiety/Panic/Nervousness/Fears
☐Phobias
☐Separation/Loss
☐Alcohol/Substance abuse
☐Body image problems
☐Suicidal thinking/attempt
☐Repetitive behaviors (i.e. compulsions)
(e.g. frequent checking, hand washing)
☐Relationships
☐Self-control
☐Decision making/Concentration
☐Assertiveness
☐Anger/Temper
☐Loneliness
☐Self-eesteem

Anything else? _____
_____
_____
_____

Have you had suicidal thoughts recently?
☐Frequently ☐Sometimes ☐Rarely ☐Never
Have you or anyone in your family been hospitalized for emotional difficulties? ☐Yes ☐No

In the past year have you been to the emergency department for mental health evaluation or psychiatric hospitalization? ☐Yes ☐No
If yes, please explain:

Please list any people with whom we can share your medical information:

OCCUPATIONAL INFORMATION

Are you currently employed? ☐Yes ☐No

If yes, who is your current employer/position? _____

If yes, are you happy at your current position? _____

Please list any work-related stressors, if any: _____

RELIGIOUS & SPIRITUAL INFORMATION
Do you consider yourself to be religious? ☐Yes ☐No

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? ☐Yes ☐No

FAMILY MENTAL HEALTH HISTORY
Has anyone in your family (immediate family members or relatives) experienced difficulties with the following? (Check any/all that apply and list family member; e.g. self, sibling, parent, uncle, cousin, etc.)

DIFFICULTY FAMILY MEMBER
☐Depression _____
☐Bipolar Disorder _____
☐Anxiety Disorder _____
☐Panic Attack _____
☐Schizophrenia _____
☐Alcohol/Substance Abuse _____
☐Eating Disorder _____
☐Learning Disability _____
☐Trauma History _____
☐Suicide Attempt _____

TRAUMA HISTORY
Please list any traumatic events or losses you or your family have endured: _____

Have you or a member of your family been exposed to verbal or physical abuse in the last year:
☐Yes ☐No Please explain: _____

Are there any weapons in your home? ☐Yes ☐No
If yes, please list: _____

LEGAL HISTORY
Are you or any of your family members currently experiencing any legal difficulties (PINS, Probation, Parole, Divorce, Custody, Arrests)? ☐Yes ☐No
If yes, please explain: _____

OTHER INFORMATION

What do you consider to be your strengths? _____

What do you like most about yourself? _____

What are effective coping strategies that you've learned? _____

What are your goals for therapy? _____

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