Kristin Ferri, LMHC, NCC
1794 Penfield Road, Upper Level
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www.Renewmhc.com
585-210-8656

Personal Information

Name: Date:

Date of Birth: Age: Gender: M / F

Relationship Status: [ ] Married [ ] Single [ ] Committed relationship [ ] Divorced [ ] Separated [ ] Widowed

Home Phone: Work Phone: Is it ok to leave a message? Y / N

Mobile Phone: Is it ok to text? Y / N

Email: Is it ok to email you? Y / N

Preferred method of contact: [ ] phone [ ]text [ ]email

Mailing Address:

Religion: Attend church: Y / N

Would you like to incorporate your faith into the counseling process? Y / N

Current Employer: Position Title:

Occupation Status: [ ] F/T [ ]P/T [ ] self-employed [ ] student

Emergency Contact Name & Relationship:

Emergency Contact Phone:

Referral Source: [ ] Website [ ] Psychology Today [ ] Social Media [ ] Thumbtack [ ] Torch [ ] Shepherds Guide

[ ] Friend/Family/Church: _____ [ ] Other: _____

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Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

[ ] 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

[ ] Increase risky behavior
[ ] Increased libido
[ ] Decrease need for sleep
[ ] Excessive energy
[ ] Increased irritability
[ ] Crying spells
[ ] Excessive worry
[ ] Anxiety attacks
[ ] Avoidance
[ ] Hallucinations
[ ] Suspiciousness

[ ] Conflict Resolution Issues
[ ] Anxious feelings
[ ] Feeling Helpless
[ ] Communication Problems
[ ] Sexual Problems in relationship
[ ] Lack of Intimacy
[ ] Codependency
[ ] Emotional Disconnect
[ ] Spiritual Concerns
[ ] Angry with God
[ ] Feel abandoned by God

Suicide Risk Assessment:

Have you ever had feelings or thoughts that you didn't want to live? [] Yes [] No
If YES, please answer the following. If NO, please skip to the next section.
Do you currently feel that you don't want to live? [] Yes [] No
How often do you have these thoughts?_____
When was the last time you had thoughts of dying? _____
Has anything happened recently to make you feel this way? _____
On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently?_____
Would anything make it better? _____
Have you ever thought about how you would kill yourself? _____
Is the method you would use readily available? _____
Have you planned a time for this? _____
Is there anything that would stop you from killing yourself? _____
Do you feel hopeless and/or worthless? _____
Have you ever tried to kill or harm yourself before? _____
Do you have access to guns? If yes, please explain. _____

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Past Psychiatric History:

Outpatient treatment [ ] Yes [ ] No If yes, Please describe when, by whom, and nature of treatment.

Reason Dates Treated By Whom

_____

_____

_____

Psychiatric Hospitalization [ ] Yes [ ] No If yes, describe for what reason, when and where.

Reason Date Hospitalized Where

_____

_____

_____

Past or Current Psychiatric Medications:

[ ] [ ] Antidepressants: _____
[ ] [ ] Mood Stabilizers: _____
[ ] [ ] Antipsychotics: _____
[ ] [ ] Sedative: _____
[ ] [ ] ADHD:_____
[ ] [ ] Antianxiety:_____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	[ ] Yes [ ] No	Suicide	[ ] Yes [ ] No
Depression	[ ] Yes [ ] No	Post-traumatic stress	[ ] Yes [ ] No
Anxiety	[ ] Yes [ ] No	Schizophrenia	[ ] Yes [ ] No
Anger	[ ] Yes [ ] No	Violence	[ ] Yes [ ] No
Alcohol abuse	[ ] Yes [ ] No	Other substance abuse	[ ] Yes [ ] No

If yes, who had each problem?

_____

_____

_____

_____

Has any family member been treated with a psychiatric medication? [] Yes [] No

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Substance Use:

Have you ever been treated for alcohol or drug use or abuse? [ ] Yes [ ] No

If yes, for which substances? _____

If yes, where were you treated and when? _____

_____

How many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____

What is the most number of drinks you will drink in a day? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

Have you ever felt you ought to cut down on your drinking or drug use? [ ] Yes [ ] No

Have people annoyed you by criticizing your drinking or drug use? [ ] Yes [ ] No

Have you ever felt bad or guilty about your drinking or drug use? [ ] Yes [ ] No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? [ ] Yes [ ] No

Do you think you may have a problem with alcohol or drug use? [ ] Yes [ ] No

Have you used any street drugs in the past 3 months? [ ] Yes [ ] No

If yes, which ones? _____

Have you ever abused prescription medication? [ ] Yes [ ] No

If yes, which ones and for how long? _____

Check if you have ever tried the following:

	YES	NO	If yes, when did you last use?
Methamphetamine	[ ]	[ ]	_____
Cocaine	[ ]	[ ]	_____
Stimulants (pills)	[ ]	[ ]	_____
Heroin	[ ]	[ ]	_____
LSD or Hallucinogens	[ ]	[ ]	_____
Marijuana	[ ]	[ ]	_____
Pain killers (not as prescribed)	[ ]	[ ]	_____
Methadone	[ ]	[ ]	_____
Tranquilizer/sleeping pills	[ ]	[ ]	_____
Alcohol	[ ]	[ ]	_____
Ecstasy	[ ]	[ ]	_____
Other: _____	[ ]	[ ]	

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

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Tobacco History:

How you ever smoked cigarettes? [ ] Yes [ ] No

Currently? [ ] Yes [ ]No How many packs per day on average? _____ How many years? _____

In the past? [ ] Yes [ ] No How many years did you smoke? _____ When did you quit?_____

How you ever smoked marijuana? [ ] Yes [ ] No

Currently? [ ] Yes [ ]No How many times per day on average? _____ How many years? _____

In the past? [ ] Yes [ ] No How many years did you smoke? _____ When did you quit?_____

Family Background and Childhood History:

Were you adopted? [ ] Yes [ ] No Where did you grow up? _____

List your siblings and their ages: _____

_____

What was your father's occupation? _____

What was your mother's occupation? _____

Did your parents' divorce? [ ] Yes [ ] No If so, how old were you when they divorced? _____

If your parents divorced, who did you live with?_____

Describe your father and your relationship with him: _____

_____

Describe your mother and your relationship with her: _____

_____

How old were you when you left home? _____

Has anyone in your immediate family died? _____

Who and when? _____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect? [ ] Yes [ ] No.

Please describe when, where and by whom: _____

_____

_____

Educational History:

Highest Grade Completed? _____ Where? _____

Did you attend college? [ ] Yes [ ] No Where? _____Major? _____

What is your highest educational level or degree attained? _____

_____

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Relationship History and Current Family:

How long have you been married? _____

If not married, are you currently in a relationship? [ ] Yes [ ] No If yes, how long? _____

What is your spouse or significant other's occupation? _____

Describe your relationship with your spouse or significant other: _____

_____

_____

Have you had any prior marriages? [ ] Yes [ ] No. If so, how many? _____

How long? _____

Do you have children? [ ] Yes [ ] No If yes, list ages and gender: _____

_____

Describe your relationship with your children: _____

_____

List everyone who currently lives with you: _____

Legal History:

Have you ever been arrested? [ ] Yes [ ] No If yes, what for?_____ How long?_____

Do you have any pending legal problems? [ ] Yes [ ] No If so, what for? _____

Spiritual Life:

Do you belong to a particular religion or spiritual group? [ ] Yes [ ] No

If yes, what is the level of your involvement? _____

Do you find your involvement helpful during this time of struggle? or does the involvement make things more difficult or stressful for you? [ ] more helpful [ ] stressful

Counseling Questions:

Have you ever been in counseling before? [ ] Yes [ ] No If yes, when? _____

If yes, how many times?_____ For how long?_____

What were you in counseling for prior? _____

_____

_____

What did you like about your previous experience?

_____

_____

What didn't you like about your previous experience?

_____

_____

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In your own words, briefly describe the reason why you now wish to come to counseling? _____

_____

_____

_____

_____

_____

In your own words, what do you wish to accomplish from counseling? _____

_____

_____

_____

_____

_____

_____ _____

Client Name **Date**

_____

Client Signature or Signature of Parent, Guardian or Personal Representative