Pathway to Equanimity, LLC
Ten Fortune Park
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Initial Client Information Form

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

Please fill out this form and bring it to your first session.

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

Name of parent/guardian (if under 18 years):
_____
(Last) (First) (Middle Initial)

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

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

Address: _____
(Street and Number)
_____
(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
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Emergency Contact#1: Name: _____ Relationship: _____
Contact number: _____

Emergency Contact#2: Name: _____ Relationship: _____
Contact Number: _____

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?
□ No
□ Yes, please list prescribing physician(s), medication name(s), and dosage(s):
_____
_____
_____

Have you ever been prescribed psychiatric medication?
□ No
□ Yes, please list prescribing physician(s), medication name(s), dosage(s), and provide dates:
_____
_____
_____

If you currently receive medical/psychiatric care, would you consider authorization for care coordination?
□ No
□ Yes

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

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
Approximate hours of sleep per night: _____

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

3. How many times per week and for how long do you generally exercise? _____

What types of exercise to you participate in _____

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

5. Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes
If yes, when did it begin and for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or having 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? □ No □Yes. If yes, please indicate number of drink(s), day(s):
_____

9. How often, if any, do you engage in 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 health (10=best)? _____

11. What significant life changes or stressful events, if any, have you experienced during the past 6 months?
_____
_____
_____

FAMILY MENTAL HEALTH HISTORY:

In the section below, please 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	List 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, approximate date of last employment _____
□ Yes, employer _____
Please describe 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, please describe your faith, belief or guiding principle:
_____
_____

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

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

_____
_____
_____
_____

5. What would you like to accomplish out of your time in therapy? How will you know when you have reached your goal(s)?

_____
_____
_____
_____
_____