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Please provide answers to the following questions that apply to you. Some of the questions may produce some anxiety or cause distressful thoughts. ***If some questions trigger feelings that seem overwhelming to you, please skip those questions until we meet, and we’ll discuss it together.*** Please understand that all information requested is for the purpose of helping me to better understand and to assist you in reaching your therapeutic goals.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Faith/Religion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Church/Synagogue:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Length of employment\_\_\_\_\_\_\_\_\_\_\_\_\_ Satisfied? \_\_\_\_\_\_\_\_\_\_\_\_\_ # of jobs in the last 5 years?\_\_\_\_\_\_\_\_\_\_\_

Highest level of education:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Completed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

College Major:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Currently in school? Y / N, # of credits:\_\_\_\_\_\_\_\_

**Please briefly explain why you are seeking therapy. What is the problem? How do you see the situation?**

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**How does this impact your social, work or academic functioning?**

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**How long have you experienced this? When did it first begin?**

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**What have you already done to try to deal with this problem?**

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**Please list prior counseling experiences you have received. (Use other side if needed)**

Psychotherapy Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date began\_\_\_\_\_\_\_\_\_\_\_ Date ended\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How was your counseling experience? Positive (helpful)\_\_\_\_\_Negative (hurtful)\_\_\_\_\_ Neutral\_\_\_\_\_\_\_

Any previous psychiatric inpatient hospitalizations or drug/alcohol rehab experiences: (Use back page if needed)

Place & Dates: Reason:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who can you count on to be your emotional support**? (circle all that apply)

Parent/parents spouse sibling(s) children coworkers church

Extended family close friends self-help group neighbor Other:\_\_\_\_\_\_\_\_\_\_\_\_\_

**When do you actually ask for or seek support?** Daily\_\_\_\_Weekly\_\_\_\_Monthly\_\_\_\_Rarely\_\_\_\_

**What is your current living/family situation? (Who is in the home? Satisfied with the current living situation?)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of pregnancies\_\_\_\_\_\_\_\_\_\_ Number of living children\_\_\_\_\_\_\_\_\_\_

 Lives with you? Quality of Relationship

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_ Y / N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_ Y / N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_ Y / N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_ Y / N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Which of the following current stressors have you experienced?**

 In Past Month In Past Year

Problem/change in Couple Relationship \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Disruption in other Family Relationships \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Death of a loved one \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

In Past Month In Past Year

Change in work status \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Change in residence \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Significant health problems \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Financial issues \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Legal issues \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

**Other significant changes or stressors?**

Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:** Please briefly explain the quality of your relationships with your mother, father and siblings while growing up (or whomever you lived with while growing up).

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Briefly indicate your birth experience. Did you have a normal birth? Were you premature, breach, or did you experience birth trauma?

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**Parents Marital Status?** Married\_\_\_\_\_Divorced\_\_\_\_\_Separated\_\_\_\_\_ Widowed\_\_\_\_\_Remarried\_\_\_\_\_

Describe their relationship (or step dad/mom with birth mom/dad):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please use 3 words to describe your parents or primary caregivers:**

Mother, Age\_\_\_\_\_\_ (or deceased?\_\_\_\_\_\_) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father, Age\_\_\_\_\_\_\_ (or deceased?\_\_\_\_\_\_) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list your siblings, their ages, and quality of relationship with you, starting with the** **oldest:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_ Deceased?\_\_\_\_\_ Quality of Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_ Deceased?\_\_\_\_\_ Quality of Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_ Deceased?\_\_\_\_\_ Quality of Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_ Deceased?\_\_\_\_\_ Quality of Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_

***Insert your name where you fit in above (in the birth order, where are you?)***

**Current symptoms (please mark those that apply):**

**Affect/Energy** **Anxiety**  **Sleep Disturbance**

Depressed mood Generalized fears Restlessness

Diminished energy Shortness of breath Excessive sleep

Diminished interest Feeling disconnected Nightmares

Increased irritability Chest pains Night Terrors

Feelings of guilt Feelings of “panic” Decreased ability to sleep

Feelings of hopelessness Hot/Cold flashes Change in sleep pattern

Poor concentration Fears of dying Waking in the middle of night

Poor decision-making ability Muscle tension No need for sleep >6 hrs per night

Increased energy, feeling “high” Worrying

Decreased energy Heart Pounding

 Stomach upset

**Eating** **Avoidance** **Post Traumatic Stress**

Increased appetite Fear of specific places Intrusive memories

Decreased appetite Fear of social situations Hyper-vigilance (over watchful)

Weight gain Constriction of life style Easily startled/High strung

Weight loss Fear of leaving the house Distressed from triggers

Binge/Purge Avoidance of many things Numb body

Compulsive Over Eating especially reminders of Uncomfortable body sensations

Not eating painful, scary events Agitated / Irritable

**Thinking/Cognitions** **Emotions** **Other**

Racing thoughts Crying spells Intense fear of abandonment

Recurring Troubling Thoughts Mood swings Impulsivity (driving recklessly,

Thought of hurting yourself Angry outbursts drinking too much, overspending..)

Thought about hurting others Numb (not feeling) Identity confusion

Hearing things others do not Unstable relationships

Seeing things others do not Strong need to be center of attention

Feeling invincible Anger control issues

Grand schemes Feeling special/unique

 Feeling you deserve better than others

 Unable to connect with others’ feeling

How much time do you spend on the internet? ( ie gaming, texting, Facebook, e-mail) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you suicidal?** Yes\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

Have you had any thoughts of suicide or ever attempted suicide? (If yes, please provide dates/details)

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**Are you homicidal?** Yes\_\_\_\_\_\_\_No\_\_\_\_\_\_\_

Have you had any thought or plans to harm another person? (If yes, please provide details)

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**Have you discussed this information with your physician?** Yes No

**When was your last physical exam?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any current medical or health problems you are dealing with? Please explain. (e.g. injuries, illnesses, allergies etc…)**

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**Please list any medications you are currently taking and why they were prescribed:**

Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_For:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Amount:\_\_\_\_\_\_\_Date Began:\_\_\_\_\_\_\_\_

Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_For:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Amount:\_\_\_\_\_\_\_Date Began:\_\_\_\_\_\_\_\_

Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_For:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Amount:\_\_\_\_\_\_\_Date Began:\_\_\_\_\_\_\_\_

Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_For:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Amount:\_\_\_\_\_\_\_Date Began:\_\_\_\_\_\_\_\_

**List any medication you have EVER been prescribed for any mental health condition: (e.g. depression, anxiety)**

Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_For:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Amount:\_\_\_\_\_\_\_Dates (from to):\_\_\_\_\_\_\_\_\_\_

Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_For:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Amount:\_\_\_\_\_\_\_Dates (from to):\_\_\_\_\_\_\_\_\_\_

**Circle Yes or No: *please describe if Yes***

Yes No Have you been engaged in any fights or acts of violence since childhood?

Yes No Have you ever inflicted harm to yourself (e.g. cutting, burning, hitting?)

Yes No Have you ever been incarcerated?

Yes No Is there any history of mental illness in your family? Please describe:

**History of abuse/trauma (Circle Yes or No):**

Yes No Has anyone ever hit, slapped, kicked, punched, or restrained you against your will?

Yes No Has anyone ever touched you in ways you were not comfortable?

Yes No Have you ever been sexually assaulted and/harassed?

Yes No Have your ever been verbally/emotionally abused?

Yes No Have you ever been abused by a church, a pastor, pastoral counselor?

Yes No Have you been mistreated and/or abused by any professional? (e.g. a therapist, doctor, instructor?)

Yes No Have you ever been threatened with serious physical harm or death?

Yes No Have you been involved in any serious auto accidents, or other accidents?

Yes No Have you experienced or witnessed war combat?

Yes No Have you experienced a serious natural disaster?

Yes No Have you witnessed a loved one experiencing any of the above?

Yes No Have you ever suffered trauma/injury to the head? *If yes, please explain:*

**Addictions/Addictive behavior:**

How many alcoholic beverages do you drink? \_\_\_\_\_\_\_\_per day \_\_\_\_\_\_\_per week

What kind of alcohol (beer, wine, vodka, etc…)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you binge drink? Yes No How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you use recreational drugs? \_\_\_\_\_\_\_\_\_per day \_\_\_\_\_\_\_\_\_per week

Name of drug choice? (e.g. cocaine, marijuana, methamphetamines, heroin, hallucinogens, etc.)

How often do you use pornography? \_\_\_\_\_\_\_\_\_\_per day \_\_\_\_\_\_\_\_\_\_per week

Do you keep this a secret from your spouse/significant other? Yes No

Are you concerned about the effects and/or the amount of time involved? Please describe:

Do you feel like you have any addictive behaviors not listed here? Please explain:

**What changes would you like to see as a result of therapy?**

1. Short term (within 6 weeks) therapeutic goals:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Long term therapeutic goals:

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**What is your present level of commitment to address the issues you are currently aware of as well as any underlying issues which may arise during the process of therapy? (please circle one)**

1 2 3 4 5 6 7 8 9 10 (10=100%)

**What expectations do you have from me as your therapist?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**What are three of your major strengths?**

1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What are some areas you want to experience growth?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**What is going well in your life (for what are you thankful)?**

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**Is there anything we haven’t talked about that is relevant or important, or that you feel I should know about?**

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**Do you have any other questions for me?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I have answered the following questions truthfully to the best of my ability. I am fully aware that based on my diagnosis, I may be referred to another therapist if my diagnosis is out of the scope of her practice.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

Print Name Signature Date