The Gateway Center for Counseling & Recovery, LLC

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

Name: _____ Date:_____
(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

Please list any children/age(s):

_____

_____

Address *(Street and Number)*:

_____

_____
(City) (State) (Zip)

Home Phone: _____ May we leave a message? □Yes □No

Cell: _____ May we leave a voicemail and/or text message? □Yes □No

Work 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.As such, no clinical information should be discussed. (Use only for generic communication, e.g. change in appointments.)

Emergency Contact regardless if a release has been signed:

Name: _____ Relationship:_____

Phone #: _____

Referred by (if any):

Name:_____ May we contact this person? _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No

□ Yes, previous therapist/practitioner/facility:

_____

Are you currently taking any prescription medication?

□ Yes

□ No

Please list:

_____

_____

Have you ever been prescribed psychiatric medication?

□ Yes

□ No

Please list and provide dates:

_____

_____

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

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in: _____

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

_____

_____

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

6. Are you currently experiencing anxiety, panic attacks or have 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 more than once a week? □ No □ Yes
If yes, # per day _____ # per week _____ Binge drinking? □ No □ Yes

9. How often do you engage recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never
Types of illicit drugs taken the past year and how frequent?

_____

_____

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? _____

11. What significant life changes or stressful events have you experienced recently:

_____

_____

FAMILY MENTAL HEALTH HISTORY:
In the section below 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.).

Family Member

Alcohol/Substance Abuse _____

Anxiety _____

Depression _____

Domestic Violence _____

Eating Disorders _____

Obesity _____

Obsessive Compulsive Behavior _____

Schizophrenia _____

Suicide Attempts _____

ABUSE HISTORY:
Have you ever been a victim of Sexual, Emotional and/or Physical Abuse? If so, by whom and for how long?

_____

_____

_____

LEGAL HISTORY:
Have you ever been arrested? _____

What charges and when? _____

_____

Current Probation/Parole Officer:_____

Officer's Location:_____

Officer's Phone # _____

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes Student? _____

If yes, name of your employer/school:

_____

_____

Do you enjoy your work/school? Is there anything stressful about your job/school?

_____

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

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

_____

_____

_____

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

_____

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

_____

_____ Date:_____
Client Signature

_____
Client Print Name

If Client is a Minor:

_____ Date:_____
Minor Signature

_____
Minor Print Name

_____ Date:_____
Parent or Guardian Signature

_____ Date:_____
Parent or Guardian Print Name

_____ Date:_____
Clinician Signature