Ryann E. Foster, LCSW
Licensed Clinical Social Worker

Please provide the following information and answer the questions below.

If the client is an adolescent, the form must be completed by the client, with parent/guardian input as needed.

Please note, the information you provide here is protected as confidential information.

Affirmed/Preferred Name: ____

Legal Name: ____ Birth Date: _____/_____/_____

Age: ________ Pronouns: ___________________ Gender: ____________ Sex Assigned at Birth _________

Emergency Contact (name & number):

____

Relationship to contact: ____

Name of parent/guardian (if under 18 years):

____ (Last) (First) (Middle Initial)

Address: ____ (Street and Number)

City: ______________________ State: ____________ Zip Code: _____________________

Phone number: _____________________________________ May I leave a message? □Yes □No

E-mail: ____ May I email you? □Yes □No

*Emails may not be confidential

Appointment Reminder Preference: □ Email □ Text (Cell Number): ______________________________

Referred by (if any): ____

Insurance Provider (if applicable):

____

Subscriber ID (if applicable): ____

Secondary Insurance Provider/ID: (if applicable):

____

Primary Physician:

____

Address:

____

Telephone number:

____

Would you like your Primary involved in your treatment? ◻ Yes ◻ No If yes, please complete consent to release information.

Family Information

Relationship Status (more than one answer may apply): ◻ Single ◻ Partnered ◻ Unmarried, living together

◻ Engaged ◻ Legally Married ◻ Separated ◻ Divorced ◻ Widowed

Relationship	Name	Age	Living?	Are they living with you?
Mother			Y/N	Y/N
Father			Y/N	Y/N
Spouse/Partner			Y/N	Y/N
Children			Y/N	Y/N
			Y/N	Y/N
			Y/N	Y/N

Significant others (e.g., brothers, sisters, grandparents, step-relatives, half-relatives, friends. Please specify the relationship.)

Relationship	Name	Age	Living?	Are they living with you?
			Y/N	Y/N
			Y/N	Y/N
			Y/N	Y/N
			Y/N	Y/N
			Y/N	Y/N

Describe your relationship with:

Parents: ____

Siblings: ____

Extended Family: ____

Spouse/Partner/Significant Other: ____

Your Children (if applicable): ____

How much is your immediate family a source of emotional support for you?

☐ Not at all ☐ Some ☐ Moderate ☐ Strong ☐ Extreme

Cultural Considerations: _______________________________________

Religion: _________________________________

Treatment History

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

□ Yes □ No

If yes, previous therapist and date: ____

Have you ever been prescribed psychiatric medication? □ Yes □ No

Please list and provide dates:

____

____

Do you take medication as prescribed? □ Yes □ No

Have you ever been hospitalized for mental health treatment? □ Yes □ No

If yes, please describe and provide dates: ____

____

General Health and Mental Health Information

How would you rate your current physical health?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very Good

Please list any specific health problems you are currently experiencing:

____

Are you currently taking any medication for the issues above? □ Yes □ No

Please list:

____

____

Do you take medication as prescribed? □ Yes □ No

Have you been hospitalized for medical concerns? □ Yes □ No

If yes, please explain: ____

____

How would you rate your current sleeping habits?

□ Inadequate □ Unsatisfactory □ Satisfactory □ Good □ Very Good

Please list any specific sleep problems you are currently experiencing:

____

How many times per week do you generally exercise? ____________

What types of exercise do you participate in?

____

Are you experiencing any difficulties with appetite or eating patterns? □ Yes □ No

Are you currently experiencing overwhelming sadness, grief, or depression? □ Yes □ No

If yes, for approximately how long?

____

Are you currently experiencing anxiety, panic attacks, or have any phobias? □ Yes □ No

If yes, when did you begin experiencing this?

____

Are you currently experiencing any chronic pain? □ Yes □ No

Are any physical characteristics or body image a concern? □ Yes □ No

Are you currently experiencing concerns related to sexuality? □ Yes □ No

Are you currently experiencing concerns related to gender? □ Yes □ No

Substance Use

How often do you engage in recreational alcohol use? □ Daily □ Weekly □ Infrequently □ Never □ In Recovery

Do you drink alcohol more than once a week? □ Yes □ No

Is alcohol an area of concern for you? □ Yes □ No

How often do you engage in recreational drug use? □ Daily □ Weekly □ Infrequently □ Never □ In Recovery

Is recreational drug use an area of concern for you? □ Yes □ No

Family Medical Health

Please check any of the family physical or mental health issues that you are aware of:

☐ Alcohol abuse ☐ Anxiety ☐ Body Image/Eating Disorder ☐ Depression ☐ Stroke

☐ Domestic Violence ☐ Drug abuse ☐ Obesity ☐ Obsessive-Compulsive Behavior ☐ Diabetes

☐ Sleep Disorder ☐ Schizophrenia ☐ Suicide/Suicide Attempts ☐ Thyroid Disorder ☐ Migraines

☐ Cancer/Type(s) ____________________________

Abuse History

Have you experienced physical, sexual, mental, or emotional abuse? □ Yes □ No

Legal History

Do you have a history of any legal charges? □ Yes □ No

If yes, please explain ____

____

Employment/Education:

Are you currently employed? □ No □ Yes

Are you currently attending school? □ No □ Yes

If yes, what is your current employment situation/current grade or level of education: ___________________________

Please describe any work-related concerns: ____

____

____

____

Name of School	Degree	Graduated (year)	Major

Other training:

____

Special circumstances (e.g., learning disabilities, gifted): ____

Is school performance a concern for you? ____

Please describe any school-related concerns: ____

____

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Additional Information:

Comments on current or past significant relationships:

____

____

____

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

____

____

____

What do you consider to be some of your strengths?

____

____

____

What do you consider to be some areas of improvement?

____

____

____

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

____

____

____