Julie Sullivan, MA, LMHC

New client information

The information you provide here is protected as confidential information.

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

 (Last) (First) (Middle Initial)

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

(Address)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s date \_\_\_\_\_\_\_\_

(City) (State) (Zip)

Phone: ( ) May I leave a message? □ Yes □ No

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

\*Please note: Email correspondence is not considered to be a confidential medium of communication.

Birth Date: \_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_\_ Age: \_\_\_\_

***If using insurance*:** Name of Ins. Co.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Toll-free#:\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s DOB \_\_\_\_\_\_\_\_\_\_

ID No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred to my practice by (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What would you like to accomplish during your time in therapy?

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

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Are you currently employed? □ No □ Yes

If yes, what kind of work do you do?:

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

 Less More

Please rate your current level of satisfaction with your work 1 2 3 4 5

Please rate your current level of stress at work 1 2 3 4 5

Have you experienced significant life changes or stressful events in the last few years?

­­­­­­­­­­­­­­­­

Please rate your level of financial stress 1 2 3 4 5

What do you consider to be some of your strengths?

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

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

If yes, describe your faith or belief:

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

Who lives in your home?:

Name Relationship to you Age

Marital Status:

□ Never Married □ Domestic Partnership □ Married □ Separated

□ Divorced □ Widowed

Please list any children /age:

If divorced, year divorced:

Residential schedule, if applicable:

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? \_\_\_\_\_\_\_\_\_\_

Are relationship issues an area you would like to work with in therapy? □ No □ Yes

If yes, please describe:

Who are your supports? (individuals, communities, spiritual, second families)

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:

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

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How would you rate your sleep (quality, quantity)? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please specify sleep problems that you currently experience:

If you have a meditative practice, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

How many times per week do you generally exercise or move your body? \_\_\_\_\_\_

How so? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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Are you currently experiencing sadness, grief or depression?

□ No □ Yes

If yes, for approximately how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently experiencing anxiety, panic attacks, or phobia? *Underline any*

If yes, when did you begin experiencing this? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What brings you joy?

Are you currently experiencing chronic pain? □ No □ Yes

If yes, please describe

10. How often do you drink alcohol? (please circle)

Daily Weekly Monthly Infrequently Never

11. How often do you engage in recreational drug use? (please circle)

Daily Weekly Monthly Infrequently Never

MENTAL HEALTH HISTORY:

Self Family Member Please specify which f.m.

Alcohol/Substance Abuse yes/no yes/no

Anxiety yes/no yes/no

Depression yes/no yes/no

Domestic Violence yes/no yes/no

Eating Disorders yes/no yes/no

Obesity yes/no yes/no

Obsessive Compulsive Behavior yes/no yes/no

Schizophrenia yes/no yes/no

Suicide Attempts yes/no yes/no

Bipolar Disorder yes/no yes/no

Attention Deficit Disorder yes/no yes/no

Trauma yes/no yes/no

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

Please list drug name, dose, current/past:

Have you previously received any type of mental health services? □ No □ Yes

If yes, please list previous therapist/practitioner/psychiatrist, approx. dates, outcome:

What did you like about your previous therapist’s approach? What, if anything, would you like to experience that is different than your previous experience(s) in psychotherapy?