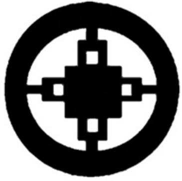

SEAN GORMAN LPC, PLLC
141 E. Mercer St. Suite D
Dripping Springs, TX 78620
512-865-6616

CLIENT INFORMATION:

Name: ____ Date: _______/ _______ / _______

Address: ____
Street City, State zip

Phone ( ) _____________________ ( ) ____________________ ( ) ____________________
Home Daytime Cell

Email: ____

Occupation_____________________________ Age: _________ Birthdate: _____ / ____ / _________

Significant Relationship Status: **o** Single **o** Married **o** Separated o Divorced/Widowed **o** Committed Relationship

How were you referred? ____

In case of emergency, whom may we contact:

Name: ____ Relationship: ______________________________

Phone: Cell ( ) ____________________ Business ( ) ________________ Other ( ) __________________

Address: ____
Street City/ State Zip Code

Briefly state what brings you in for help today:

____

____

____

____

What are your goals for therapy?

____

____

____

____

MENTAL HEALTH HISTORY: (*feels free to use the back of this form to add more information)*

Have you had any previous counseling or psychotherapy? O Yes O No
If yes, please specify when & why: ____

Have you ever been diagnosed with any of the following mental health conditions?

Depression O Yes O No
Bipolar Disorder O Yes O No
Anxiety/Panic Disorder O Yes O No
Post-traumatic Stress Disorder O Yes O No
Eating Disorder O Yes O No
Obsessive Compulsive Disorder O Yes O No
ADD/ADHD O Yes O No
Schizophrenia or Psychosis O Yes O No
Substance Abuse Issues O Yes O No
Other: _________________________________

MEDICATIONS:

Have you ever been prescribed medication for mental health concerns? O Yes O No
If yes, what medications & for what conditions? ____

Are you still taking medications for mental health concerns? O Sometimes O Yes O No

If yes, what medications & for what conditions: ____

Who is your prescriber? ______________________________ May I contact them if needed? O Yes O No
If you are no longer taking medication, did you stop on your own? O Yes O No
I discontinued my medication because: ____

List any other current non-psychiatric medications you take: _______________________________________

Are you experiencing any of the following? (please circle yes or no)

Depression:	Yes	No
Loss or increase in appetite:	Yes	No
Loss of interest in activities:	Yes	No
Significant weight loss or gain:	Yes	No
Increase or decrease in sleep:	Yes	No
Increase or decrease in energy level:	Yes	No
Thoughts about death, suicide, or self-harm:	Yes	No
Eating in excess:	Yes	No
Concerns about body image:	Yes	No
Feelings of worthlessness or guilt:	Yes	No
Anxiety:	Yes	No
Panic or anxiety attacks:	Yes	No
Fears:	Yes	No
Nightmares:	Yes	No

Persistent unpleasant thoughts: Yes No
Worries about physical health, finances, other: Yes No
Problems in concentration or decision making: Yes No
Times when you engage in repetitive behaviors: Yes No

SUBSTANCE ABUSE HISTORY

How many times during the month do you consume alcohol?

How much do you drink each time?

Do you use any illegal drugs (Marijuana, Cocaine, Amphetamines, Heroin, other)? Yes No
If yes, please list below.

Have you used any illegal drugs in the past? Yes No
If yes, please list below, and time of last use. ____

Have you ever abused prescription medications or over-the-counter medications such as pain medications, narcotics, anxiety medications, tranquilizers, or sleeping medications? Yes No
If yes, please describe below:

Have you ever participated in NA/AA or other self-help programs? Yes No

How many caffeine products (soda, coffee, energy drinks) do you consume each day?

Do you use tobacco products? Yes No
If yes, please describe below what you use and how much

Does anyone in your family have a history with substance abuse or use? If yes, please state who and their relationship to you.