Juniper Campbell, LPC

GENERAL INFORMATION

Patient Name:_____ Date of Birth:__/__/__ Age:____
Gender: [ ] Male [ ] Female
Home Address:_____
City_____ State_____ Zip Code_____

Home Phone Number:_____ May I leave a message? [ ] Yes [ ] No
Work Phone Number:_____ May I leave a message? [ ] Yes [ ] No
Cell Number:_____ May I leave a message? [ ] Yes [ ] No

If the above patient is a minor complete the following:
Name of Guardian:_____
Address of Guardian:_____
City_____ State_____ Zip Code_____

Guardian's Home Phone Number:_____ May I leave a message? [ ] Yes [ ] No
Guardian's Work Phone Number:_____ May I leave a message? [ ] Yes [ ] No
Guardian's Cell Number:_____ May I leave a message? [ ] Yes [ ] No

Emergency Contact:
Name of contact:_____ Relation to patient:_____
Phone number:_____

INSURANCE INFORMATION:

Primary Insurance Company:_____ Policy Holder:_____
Policy Holder date of birth:_____ Relationship to Client:_____
Policy #:_____ Group number:_____
Insurance Contact #:_____
Secondary Insurance Company: _____ Policy #:_____
Group number: _____Insurance Contact #:_____

INTERPERSONAL HISTORY

Marital Status: [ ] Single [ ] Married [ ] Separated [ ]Divorced [ ] Widowed [ ] Other
Children (Please list name, age and sex):_____
_____

Were you raised by: [ ] Both parents? [ ] Single parent? [ ] Relative? [ ] Adopted? [ ] Other?

In your family is there a history of: [ ] Alcoholism [ ] Drug Addiction [ ] Mental Illness [ ] Prolonged physical illness_____
Do you have a good support system: [ ] Yes [ ] No

MEDICAL/MENTAL HEALTH HISTORY

Current Medications and Dosages:_____
_____
_____
Do you have any significant medical problems:_____
_____
Did you meet all of your developmental milestones: [ ] Yes [ ] No

Have you had previous psychiatric care and/or counseling: [ ] Yes [ ] No
Name of Clinician:_____ Sessions from: _____to_____
Have you ever received a formal mental diagnosis: [ ] Yes [ ] No
If yes, please provide diagnosis:_____

Have you ever been hospitalized for issues related to your mental health [ ] Yes [ ] No
If yes, when, where and for what reason:_____
_____

Do you have a trauma history (physical, sexual, emotional) [ ] Yes [ ] No
If Yes, please give a brief description of the nature of the trauma, who was involved and when it occurred:
_____
_____

OCCUPATION/EDUCATION/MILITARY

Level of Education:_____
Current Employment:_____

Are you a veteran?: [ ] Yes [ ] No
If yes, Branch of military:_____ Rank:_____
What jobs did you have in the military:_____
What dates and where did you serve:_____
Did you see combat [ ] Yes [ ] No Enemy Fire [ ] Yes [ ] No Casualties [ ] Yes [ ] No
Do you have family members that served in the military:_____

LEGAL INFORMATION

Are there any present or past legal issues (arrest history, DUI, incarceration, litigation):_____
_____

LIFESTYLE INFORMATION

How many times a week do you exercise and what type of exercise do you prefer: _____
_____
Describe your eating habits (do you eat three meals a day, vegetables, fruits, meat, snacks, late night eating...):
_____
What junk food do you love to eat (soda, chocolate, chips...) and how often do you eat these foods:_____
_____
What supplements do you take: _____
_____

If you drink alcohol, what are your drinking habits: [ ] rarely drink [ ] 1-3 times per week [ ] 3-5 times per week[ ] everyday [ ] don't intend to drink as much as I do sometimes [ ] black out when drinking [ ] drink to get drunk

How much sleep do you get: [ ] 3-5 hrs per night [ ] 5-7 hrs [ ] 7-9 [ ] 9-12

How much television do you watch: [ ] none [ ] 1-2 hrs. a day [ ] 2-4 hrs. a day [ ] 4-6 hrs. a day [ ] 6+ hrs. a day
How much time do you spend playing video games: [ ] none [ ] 1-2 hrs. a day [ ] 3+ hours a day
How much time do you spend on social media: [ ] none [ ] 1-2 hrs. a day [ ] 3+ hours a day

How do you sabotage yourself and your goals: _____
_____

PERSONAL AND THERAPEUTIC GOALS

What are 3 goals that you would like to work towards in therapy:
1. _____
2. _____
3. _____

Name 3 of your strengths:
1. _____
2. _____
3. _____

Check all words/phrases that describe what you are experiencing:

[ ] Substance abuse/dependence
[ ] Addiction (ex. porn, shopping, alcohol, gaming...)

[ ] Feeling of being sad or blue for no reason
[ ] Crying a lot for no reason
[ ] Having a hard time falling asleep or staying asleep
[ ] I sleep too much
[ ] Things I used to enjoy are no longer fun or enjoyable
[ ] Decreased motivation
[ ] Withdrawing from people/Isolating
[ ] High or Low energy levels
[ ] Change in weight or appetite
[ ] Feelings of hopelessness or worthlessness
[ ] Feelings of shame or guilt
[ ] Suicidal thoughts or a plan
[ ] I have attempted suicide
[ ] Self-harm/Cutting/Burning yourself
[ ] Homicidal thoughts or plans to hurt others

[ ] Angry/Irritable
[ ] Mood swings
[ ] Negative thinking
[ ] Poor concentration
[ ] I am distracted easily
[ ] I have a hard time sitting still
[ ] I act as if I am driven by a motor
[ ] I have a hard time listening when people talk to me

[ ] Anxious/Nervous/Tense Feeling
[ ] Panic Attacks
[ ] I am afraid of certain objects or situations
[ ] Racing and Scrambled thoughts
[ ] Bad or Unwanted thoughts
[ ] Flashbacks/Nightmares
[ ] I have experienced a traumatic event

[ ] Hearing voices/Seeing things that are not there
[ ] Paranoid Thoughts
[ ] Rituals (ex. counting, washing hands, fear of germs)

[ ] Distorted body image (believing you are heavier than you are or less attractive)
[ ] Feelings of loss of control over eating
[ ] Binge eating/Purging
[ ] Rules about eating
[ ] Excessive Exercise

[ ] Career/Job concerns
[ ] Thoughts of Running Away
[ ] Other