Sonja Benson, Ph.D., PLLC
Licensed Psychologist

Date_____ Referred by_____

Name_____

Date of Birth_____ May I thank referral source? _____

Address_____

City_____ State_____ Zip code_____

Daytime Phone_____ Nighttime Phone_____

Cell Phone_____ Email_____

Male( ) Female ( ) Ethnicity_____ Age_____

Occupation _____

Marital Status_____ Spouse's Name if married_____

Emergency Contact Person/Relationship_____

Phone/Address for Emergency Contact: _____

_____

Family Information

People **Currently** Living in your Household

Name	Relationship	Age	Birthplace	Occupation or Grade Level

Family of Origin Members-Who You Grew Up With (parents, siblings, etc)

Name	Relationship	Age	Where Living	Occupation or Grade Level

Do you have any children not living with you? If yes, please list their names, ages, and where living: _____
_____

Has any member of your family been hospitalized for mental health concerns?_____
If yes, please list who, when and for what reason:
_____
_____
_____
_____

Do/did you have any family members who have/had problems with drinking alcohol or using drugs? _____
If yes, please list who, when and if it is still a problem:
_____
_____
_____
_____

Has any member of your family killed themselves or tried to kill themselves? _____
If yes, please list who, when, and what happened:
_____
_____
_____
_____

What is your **worst** memory about your family when growing up? _____

_____
_____
_____
_____

What is your **best** memory about your family when growing up? _____
_____
_____
_____

If you could change anything about your family situation right now, what would it be?
_____
_____
_____
_____
_____

Health/Mental Health Information

Have you ever seen a counselor, psychologist, psychiatrist or other mental health professional for any mental health or drug/alcohol concerns? _____
If yes, please list who, when, and why:
_____
_____
_____
_____

Have you ever been hospitalized for mental health or drug/alcohol concerns?_____
If yes, please list when and for what reason:
_____
_____
_____
_____

Do you have thoughts of killing yourself? _____ If yes, how often does this happen? _____ Have you ever tried to kill yourself? _____ If yes, when was this? _____ Did you receive medical help? _____

Please check any of the following areas that you have experienced:
( ) Head Injury ( ) Loss of Consciousness ( ) Seizures ( ) Convulsions

If yes, please explain: _____

Current Medications
(Please include prescription, over the counter, herbs, vitamins, and other remedies)

Medication	Dosage and When Taken	Reason for Taking

Past Medications

(Particularly those taken for Mental Health Concerns)

Medication	Dosage and When Taken	Reason for Taking

Have you ever had surgery/been hospitalized? _____ If yes, please list when, where, why and type of surgery/hospitalization

_____

_____

_____

_____

Height _____ Weight _____ Has your weight gone up or down by more

than a few pounds in the past 3 months? _____ If yes, how much? _____

Are you satisfied with your weight? _____

Please list any **current** health concerns: _____

_____

_____

_____

Please list **past** serious illnesses and health concerns: _____

_____

_____

_____

Exercise and Physical Recreational Activity

Type of Activity	How often

Would you describe yourself as physically active? _____

Are you more or less active than 3 mos ago? _____ 6 mos ago? _____

Please list any history of abuse (physical/sexual/emotional):_____
_____
_____
_____

For those in a sexual relationship: Please describe the health and/or challenges of your sexual relationship and functioning.
_____
_____
_____
_____

Please note any infidelities, either physical or emotional, and by which partner:_____
_____
_____
_____
_____

Use of Substances (On Average)

	Current Amount	Most Used in the Past
Alcohol	_____ glasses per day or _____ glasses per week	_____ glasses per day or _____ glasses per week
Tobacco	_____ cigarettes per day	_____ cigarettes per day
Caffeine (tea, coffee, soda)	_____ servings per day	_____ servings per day
Marijuana	_____ per day or _____ per week	_____ per day or _____ per week
Cocaine	_____ times per day or _____ times per week	_____ times per day or _____ times per week
Diet Pills	_____ pills/doses per day or	_____ pills/doses per day or

Name: _____	_____ pills/doses per week	_____ pills/doses per week
Laxatives	_____ times per day or _____ times per week	_____ times per day or _____ times per week
Stimulants Name: _____	_____ pills/doses per day or _____ pills/doses per week	_____ pills/doses per day or _____ pills/doses per week
Painkillers Name: _____	_____ doses per day or _____ doses per week	_____ doses per day or _____ doses per week
Other Name: _____ Name: _____	Amount:	Amount:

What if any relationships do you have that are not going well at this time? _____
_____
_____
_____

What if any relationships do you have that are supportive and fulfilling at this time?
_____
_____
_____

What are your strengths? _____
_____
_____
_____
_____

How is your work life
currently?_____
_____
_____

Please check any symptoms that describe how you feel, think, or behave currently or during the past few weeks:

( ) Chronic sadness
( ) Crying episodes
( ) Hopelessness
( ) Low frustration tolerance
( ) Irritability
( ) Sleep problems

( ) Difficulty concentrating
( ) Loss of appetite
( ) Overeating
( ) Nausea/Vomiting
( ) Difficulty making decisions
( ) Low energy/fatigue
( ) Agitation
( ) Restlessness
( ) Excessive worry
( ) Fearfulness
( ) Trembling/shaking
( ) Fear of loss of control
( ) Fear of dying
( ) Intrusive thoughts of bad memories
( ) Flashbacks/re-living bad experiences
( ) Hear voices others do not hear
( ) Fearful others are talking about me
( ) Difficulty completing tasks/distracted
( ) Difficulty focusing
( ) Tendency to act impulsively
( ) Not well organized
( ) Legal Problems
( ) Difficulty at work
( ) Racing thoughts
( ) Excessive spending
( ) Excessive gambling
( ) Aggressive/abusive toward others
( ) Tried to kill myself

( ) Memory problems
( ) Thoughts of suicide
( ) Withdrawing from others
( ) Difficulty functioning at work
( ) Difficulty functioning socially
( ) Reduced interest/pleasure in activities
( ) Panic attacks
( ) Fear of leaving home
( ) Avoidance of public places
( ) Avoidance of social situations
( ) Pounding heart/palpitations
( ) Shortness of breath
( ) Feeling detached from others/life
( ) Nightmares
( ) Easily startled/upset
( ) Seeing things others do not see
( ) Fearful someone is plotting against me
( ) Taking on too many tasks
( ) Frequent forgetfulness
( ) Difficult to wait my turn
( ) Problems with co-workers
( ) Problems in school growing up
( ) Hard to stay with a job very long
( ) Staying up for days without sleep
( ) Multiple sexual partners
( ) Marital conflict
( ) Confused/worried about sexual behavior
( ) Thoughts of physically hurting others

Please describe why you are seeking help at this time: _____
_____
_____
_____
_____
_____
_____
_____
_____