Envision Beyond Counseling

Please take time to review and fill out the forms. This information is confidential and will help to better assess your needs.

Personal Information

Name: _____

Preferred Name: _____

Preferred Gender Pronoun: _____

Date of Birth: _____ SSN: _____

Culture/Race/Ethnicity: _____

Religious/Spiritual Affiliation: _____

Address: _____City: _____ Zip:_____

Home Phone: _____

Cell Phone: _____

Email: _____

*Please note that e-mail is not considered a confidential medium of communication.

*I give permission to be contacted about appointment reminders by:

☐ Text message ☐Phone call ☐E-mail

I prefer information to be left via: ☐Cell ☐Home ☐Other

Marital Status:☐Single ☐Married/Domestic Partnership ☐Separated ☐Divorced ☐Widowed

Employment Status: ☐Employed ☐Self-Employed ☐Retired ☐Unemployed ☐Student

Please list your profession: _____

If applicable, please list your employer:

_____

On average, how many hours do you work? ☐35+ ☐15-35 ☐0-15

Primary Language: _____

Do you currently attend school? ☐No ☐Yes

If applicable, please list the school you attend:

_____

Highest level of education: _____

Days and Times to best schedule appointments:

_____

How did you hear about Envision Beyond Therapy?

_____

Please describe the main reason you are seeking therapy and what you hope to gain:

Emergency Contact

Name: _____

Relationship: _____ Phone: _____

Medical and Health

Primary Care Physician: _____ Phone: _____

Primary Psychiatrist: _____ Phone: _____

How would you rate your current physical health status?

☐Poor ☐Fair ☐Average ☐Good ☐Very Good ☐Excellent

Please list any current medical conditions:

How would you rate your sleeping habits?

☐Poor ☐Fair ☐Average ☐Good ☐Very Good ☐Excellent

Please list any specific sleeping issues you may have:

How many times per week do you typically exercise? _____
Please list the kind of exercise you usually participate in:

Are you currently taking any prescribed medications for health? ☐No ☐Yes

If yes, please list:

Have you ever taken prescribed psychiatric medications? ☐No ☐Yes

If yes, please list current medications first and dates of previous medications taken:

Do you have any allergies? ☐No ☐Yes

If yes, please list:

Have you previously received any mental health services (psychotherapy, psychiatric, holistic)?

☐No ☐Yes (Please name previous therapist/practitioner) _____

Please describe your experience:

Symptom Assessment

Experience	Never	Several Days	More Than Half the Days	Nearly Everyday	Everyday
Having little interest or pleasure in doing things	○	○	○	○	○
Feeling down, depressed, or hopeless	○	○	○	○	○
Trouble staying asleep or falling asleep or sleeping too much	○	○	○	○	○
Feeling tired or little energy	○	○	○	○	○
Poor appetite or overeating	○	○	○	○	○
Feeling bad about yourself or that you are a failure or let someone or your family down	○	○	○	○	○
Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○	○
Moving or speaking so slowly that other people could have noticed or so fidgety or restless that you have been moving a lot more than usual	○	○	○	○	○
Thoughts that you would be better off dead, or thoughts of hurting yourself in some way	○	○	○	○	○
I think about all the things I have not accomplished	○	○	○	○	○
“Flashbacks” to traumatic events	○	○	○	○	○
Become irritable or easily annoyed	○	○	○	○	○
Trouble relaxing	○	○	○	○	○
Focus on upsetting situations	○	○	○	○	○
Unable to stop or control worrying	○	○	○	○	○
A sense of worry or fear	○	○	○	○	○

Experience	Never	Several Days	More Than Half the Days	Nearly Everyday	Everyday
Anxiety or panic attack	○	○	○	○	○
Repetitive and persistent thoughts of anxiety	○	○	○	○	○
Overwhelmed thoughts that cause a shortness of breath, pain in the chest or other parts of the body, pounding heart, sweating, choking, or dizziness	○	○	○	○	○
Feelings of loss or bereavement	○	○	○	○	○
Social isolation or loneliness	○	○	○	○	○
Discomfort in social situations	○	○	○	○	○
Avoid places or situations	○	○	○	○	○
My moods change quickly	○	○	○	○	○
Racing thoughts	○	○	○	○	○
Memory problems or difficulty remembering	○	○	○	○	○
Hearing voices	○	○	○	○	○
Acting without concern of consequences	○	○	○	○	○
Been physically harming self	○	○	○	○	○
Restrict food intake	○	○	○	○	○
Force vomit	○	○	○	○	○
Binge eat	○	○	○	○	○
Took more than the recommended amount of laxatives	○	○	○	○	○
Drastic weight gain or loss	○	○	○	○	○
Concern about sexual functioning	○	○	○	○	○

Discomfort engaging in sexual activities	○	○	○	○	○
Question sexual orientation	○	○	○	○	○

Substance Use

Substance	Use	Frequency	Amount	Last Use
Alcohol	○			
Nicotine (Cigarettes/Juul)	○			
Marijuana	○			
Opiates	○			
Cocaine	○			
Hallucinogens	○			
Methamphetamines	○			
Sedatives	○			
Stimulants	○			

Signatures

Client Name	Signature	Date

Parent/Guardian Name	Signature	Date

Provider Name	Signature	Date