Jana Grimes, LMHC, CDP

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**Patient Information**

Patient Name (first, last, middle initial): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street City State Zip

*Check box if OK to leave message and/or email:*  
Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_☐

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_☐ \**E-mail is not considered a confidential means of communication.*

**Reasons for treatment and objectives:**

What are your primary reasons for seeking treatment?

Briefly describe the history and development of this issue from onset to present.

What attempts have been made so far to remedy this issue?

Why are you choosing to partake in therapy **now**?

Have you previously received mental health services of any kind? Yes ☐ No ☐

Dates and type of treatment:

Focus of previous treatment:

How would you describe your previous experiences in therapy if applicable?

**Medical & General Health:**

Name of Personal Physician/Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all current medical conditions including food and medication allergies:

List all current medications including dosages:

Have you ever taken any psychiatric medication?  
☐No  
☐Yes, please list and provide dates:

In the section below please identify if there is a family history of any of the following. If yes, please list the family member’s relationship to you (mother, father, uncle grandmother, etc).

|  |  |  |
| --- | --- | --- |
|  | Please Circle | List of all family members affected |
| Alcohol/Substance Abuse | Yes No |  |
| Anxiety | Yes No |  |
| Bipolar | Yes No |  |
| Depression | Yes No |  |
| Domestic Violence | Yes No |  |
| Eating Disorder | Yes No |  |
| Obsessive Compulsive Disorder | Yes No |  |
| Schizophrenia | Yes No |  |
| Suicide Attempts | Yes No |  |

1. How would you rate your overall health?  
☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Very Good

Please list any specific health problems you are having:

2. How would you rate your current sleep habits?

☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Very Good

3. Are you currently engaging in physical activity?  
☐No  
☐Yes \_\_\_\_\_\_\_\_\_\_\_ days per week. Type of exercise \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Have you recently experienced or are you currently experiencing any stressful events or life changes?

**Current Symptoms**: Please check any of the following that pertain to you:

|  |  |  |  |
| --- | --- | --- | --- |
| ☐Anxiety | ☐Anger | ☐Appetite Disturbance | ☐Binging |
| ☐Compulsions | ☐Decreased Energy | ☐Depression | ☐Elevated Mood |
| ☐Grief/loss | ☐Guilt | ☐Hallucinations | ☐Hopelessness |
| ☐Hyperactivity | ☐Irritable | ☐Mania | ☐Memory Issues |
| ☐Obsessions | ☐Oppositional | ☐Panic Attacks | ☐Paranoia |
| ☐Poor Concentration | ☐Poor Impulse Control | ☐Poor Self-Esteem | ☐Purging |
| ☐Self-Injury (cutting) | ☐Sleep Disturbance | ☐Weight gain/loss | ☐Withdrawn |

Other:

**Current Functioning**: Please check any of the following that pertain to you:

|  |  |  |  |
| --- | --- | --- | --- |
| ☐ Noticeable decrease in productivity | ☐ Fewer social contacts | ☐ Decrease in care to children or pets | ☐ Suspension from work/school |
| ☐ Drop in grades or work performance | ☐ Medication misuse or non-compliance | ☐ Argumentative | ☐ Absent 2 or more days from school/work |
| ☐ Medical LOA due to psychiatric problem | ☐ Difficulty finding motivation |  |  |

**Additional Information**

1. Are you currently employed? ☐No ☐Yes

If yes, please describe employment situation:

Please describe any work related stressors:

2. Do you consider yourself to be spiritual or religious? ☐No ☐Yes

If yes, please describe your faith or belief :

3. Are you currently in a romantic relationship? ☐No ☐Yes  
If yes, for how long?

On a scale from 1-10, how would you rate your relationship?

4. What do you consider to be some of your strengths?

5. What would you like to accomplish by the end of therapy?

**Emergency Notification**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(First) (Last) (Middle Initial)

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client Signature**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian Signature (younger than 13) Date