Henryetta Bergstresser

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About You:

Name: _____ _____ ____ / ____ / _____
Legal Name | Name you prefer I use | Date Of Birth

Contact: ( ) _____ ( ) _____ _____
Cell Phone # | Home Phone # | E-Mail Address

If you need additional space please use the last page or back side and number the responses.

Your Goals:

1. How did you find me as your therapist (e.g., friends' recommendation, doctors referral, Google search, provider directory search, etc.)?

2. What is the reason you are coming in for counseling? Is there something specific, such as a particular event? When did this start or happen? How is your life affected by this issue? Please be as detailed as you can.

3. What are your goals for our work together?

Your History:

4. Do you engage in, or have you ever engaged in, self-harm (e.g., cutting, scratching, hair-pulling, etc.)?
   Yes ☐ No ☐
   If "yes", please describe:

5. Do you have, or have you ever had, suicidal thoughts?
   Yes ☐ No ☐
   Is there anything you'd like to share with me about that?

6. Have you ever attempted suicide?
   Yes ☐ No ☐
   Is there anything you'd like to share with me about that?

7. Do you have, or have you ever had, thoughts or urges to harm someone else or damage their property?
   Yes ☐ No ☐
   Is there anything you'd like to share with me about that?

8. Is there a history of mental illness in your family?
   Yes ☐ No ☐
   If "yes", please describe:

9. Have you ever been hospitalized for a psychiatric issue?
   Yes ☐ No ☐ If "yes", please provide the following details:
   Where were you hospitalized?
   When?
   Why?
   For how long?
   Did you receive a diagnosis?
   Did the hospitalization help?

YOUR SLEEP AND REST:

10. With "0" being very poor and "10" being the very best, how would you rate your sleep?

11. How many hours of sleep do you typically get?

12. Do you feel rested upon waking?

13. Do you sleep continuously, or do you toss and turn?

14. How often do you wake up in your sleep?

15. If you wake up in your sleep, how long before you fall back asleep?

YOUR DIET AND EXERCISE:

16. What do you find yourself typically eating?

17. Do you eat regular meals throughout the day?

18. Do you think your meals are balanced?

19. Do you exercise? If so, what do you do for exercise?

20. How often do you exercise?

21. How long is an exercise session, if any?

YOUR WORK AND RELATIONSHIPS:

22. What do you like to do for fun or enjoyment? Do you have any hobbies or activities that you enjoy regularly? Do you prefer doing these activities alone, with others, or both?

23. Who do you would consider your closest sources of support or your "inner circle"?

24. Describe your current living situation. Do you live alone, with others, with family, etc.? Is there a reason for your particular living situation?

25. If you are in a relationship, please describe the length and nature of the relationship.

26. What is your current occupation? How long have you been doing it?

27. What is your highest completed grade level? If you have a degree, what type and in what subject?

YOUR MEDICAL HISTORY:

28. Please check any of the following you have experienced in the past six months:

- ☐ Increased appetite
- ☐ Decreased appetite
- ☐ Trouble concentrating
- ☐ Difficulty sleeping
- ☐ Excessive sleep
- ☐ Low motivation
- ☐ Isolation from others
- ☐ Fatigue / low energy
- ☐ Low self-esteem
- ☐ Depressed mood
- ☐ Tearful of crying spells
- ☐ Anxiety
- ☐ Fear
- ☐ Hopelessness
- ☐ Panic
- ☐
- ☐
- ☐

29. Please check any of the following medical conditions that apply:

☐ Headaches	☐ Bone of joint problems	☐ Shortness of breath
☐ High blood pressure	☐ Seizures	☐ Diabetes
☐ Gastritis, esophagitis, ulcers	☐ Kidney-related issues	☐ Hepatitis
☐ Hormone-related issues	☐ Chronic fatigue	☐ Asthma
☐ Head injury	☐ Dizziness	☐ Arthritis
☐ Angina and/or chest pain	☐ Faintness	☐ Thyroid issues
☐ Irritable bowels	☐ Heart valve problems	☐ HIV/AIDS
☐ Chronic pain	☐ Urinary tract problems	☐ Cancer
☐ Loss of consciousness	☐ Fibromyalgia	☐
☐ Heart attack	☐ Numbness and/or tingling	☐

30. List all psychotropic medications you are currently taking, how long you have been taking them, and for what reason(s). What is the dosage of each? What time of day do you take the medication (morning, evening, bedtime)? Does it help?

31. Have you seen a mental health professional before? If so, please specify date(s), the reason(s) for counseling, and your experience. What was your diagnosis, if any?

32. If taking prescription medication, who is your prescribing doctor? Please include type of doctor, name, and phone number.

33. Who is your primary care doctor? Please include the type of doctor, name, and phone number.

34. Do you smoke cigarettes or use any nicotine products? If so, what and how often? Do you use them during normal sleeping hours?

35. Do you currently drink alcohol? If so, describe the type, amount, and how often (daily, weekly, monthly, etc.).

36. Do you currently use recreational drugs? If so, describe type, amount, and frequency.

37. Have you experienced any problems that are legal (e.g., police or court), medical (health-related), relationship (family, marriage, or partner), or employment (job-related) due to alcohol or drug use?

38. What else would you like me to know?