STRONG LOVING CONNECTIONS
Ellen Schrier, MS, LPC, NCC
716 North BethlehemPike, Suite 203
Lower Gwynedd, PA 19002

CLIENT INITIAL SESSION FORM

Please answer the following questions to the best of your ability. These questions are intended to help me with the therapy process. All information is completely confidential.

Personal Information

Name:_____ Birth Date _____Age _____

Spouse Name _____
(Last) (First) (Middle Initial)

Name of parent or guardian (if minor):_____
(Last) (First) (Middle Initial)

Current Address: _____

_____

_____

Home Phone:_____ May we leave a message? □ Yes □ No

Cell/other:_____ May we leave a message? □ Yes □ No

Email: _____ May we leave a message? □ Yes □ No

Would you like to subscribe to our Strong Loving Connections newsletter? □ Yes □ No

**NOTE: Email correspondence and text messages are not guaranteed as a confidential method of communication.*

Marital Status: □ Never married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Date of Marriage _____ Years Married _____ Years Lived Together Before Marriage _____

Prior Marriages _____

Children: Name Sex Date of Birth Is child yours, partner's or both?

_____

_____

_____

_____

Referred by/How did you find me: _____

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Name of Prescribing Physician _____Phone Number _____
Name of Psychiatrist _____ Phone Number _____

Are you currently receiving psychological services, professional counseling, psychiatric services, or any other mental health services? □ Yes □ No
Reason for change:_____

Have you had any mental health services in the past? □ Yes □ No
Describe:_____

Are you currently taking any psychiatric prescription medications? □ Yes □ No
If yes, please list: _____ _____ _____

Have you ever been prescribed a psychiatric prescription medication? □ Yes □ No
If yes, please list: _____ _____ _____

General Health and Mental Health Information

How is your physical health at the present time?
□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good
Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, thyroid dysfunction, etc.: _____
_____

Are you on any medication for physical/medical issues? □ Yes □ No
If yes, please list:_____ _____
_____ _____

Are you having any problems with your sleep habits? □ Yes □ No
If yes, check which applies: □ Sleep too much □ Sleep too little □ Poor quality □ Disturbing dreams
Other:_____

How many times per week do you exercise? _____days _____minutes/hours

Are there any changes or difficulties with your eating habits? □ Yes □ No
If yes: □ Eating less □ Eating more □ Binging □ Restricting

Have you experienced a weight change in the last two months? □ Yes □ No

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If yes, describe_____
_____

Do you consume alcohol regularly? □ Yes □ No How many drinks per week? _____
In one month, how many times do you have 4 or more drinks in a 24-hour period?_____

How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Rarely □ Never

Have you ever felt the need to cut down on your alcohol or drug use? □ Yes □ No
Have some people criticized your use or shared concerns about it? □ Yes □ No
Have you felt guilty, worried or stressed about your drinking or drug use? □ Yes □ No
Describe any alcohol or drug related details or concerns: _____
_____
_____

Have you felt sadness, grief or depressed recently? □ Yes □ No
If yes, when did this start experiencing this and for how long? _____
Describe: _____
_____
_____

Have you had any thoughts of hurting yourself or suicidal thoughts recently? □ Yes □ No
If yes: □ Frequently □ Sometimes □ Rarely
Describe:_____
_____

Have you had thoughts of hurting yourself or suicidal thoughts in your past? □ Yes □ No
If yes, how long ago?_____ How often? □ Frequently □ Sometimes □ Rarely
Describe: _____
_____

Have you had any suicide attempts? □ Yes □ No
Describe circumstances/dates: _____
_____

Are you currently experiencing anxiety, panic attack, obsessions, compulsions, fears or phobias? □ Yes □ No
If yes, when did you begin experiencing this? _____

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Describe_____
_____
_____

Are you currently in a romantic relationship? □ Yes □ No
If yes, how long have you been in this relationship?_____

On a scale from 1-10, how would you rate the quality of your relationship (10 being great)? _____

In the last year, have you had any major life changes (e.g. new job, new home, illness, relationship change, etc.)?
_____
_____

Quick Check

Check the boxes of the symptoms you have experienced.

□ Extreme depressed mood	□ Mood swings	□ Rapid speech	□ Extreme anxiety
□ Panic attacks	□ Phobias	□ Disturbed sleep	□ Hallucinations
□ Memory lapse	□ Alcohol/substance abuse	□ Body complaints	□ Eating disorder
□ Repetitive thoughts	□ Anxiety	□ Time loss	□ Repetitive behaviors
□ Homicidal thoughts	□ Suicide attempts	□ Trouble planning	□ Relationship trouble

Occupational Information

Are you currently employed? □ Yes □ No
If yes, who is your employer?_____What is your position?_____
Are you happy in your current position? □ Yes □ No
Are you fulfilled in your current position? □ Yes □ No
Does your work make you stressed? □ Yes □ No
If yes, what are your work-related stressors?_____

Religious/Spiritual Information

Do you practice a religion? □ Yes □ No If yes, what is your faith? _____
If no, do you consider yourself to be spiritual? □ Yes □ No

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Family Mental Health History

The following is to provide information about your family history. Please, mark each as yes or no. If yes, please indicate the family member affected.

Issue			*Family Member*
Attention Deficit Disorder (ADHD)	□ Yes	□ No	_____
Alcohol/Substance Abuse	□ Yes	□ No	_____
Anxiety	□ Yes	□ No	_____
Depression	□ Yes	□ No	_____
Domestic Violence/Abuse	□ Yes	□ No	_____
Eating Disorder	□ Yes	□ No	_____
Learning Disability	□ Yes	□ No	_____
Obesity	□ Yes	□ No	_____
Obsessive Compulsive Behavior	□ Yes	□ No	_____
Panic Attacks	□ Yes	□ No	_____
Phobias	□ Yes	□ No	_____
Schizophrenia	□ Yes	□ No	_____
Suicide/Attempts	□ Yes	□ No	_____
Trauma History	□ Yes	□ No	_____
Borderline Personality Disorder	□ Yes	□ No	_____
Bipolar Disorder	□ Yes	□ No	_____

What words describe the home in which you were raised (ex. Loving, unsafe, hectic, etc.)

_____

What words come to mind when you think of your parent's relationship to each other?

_____

Are your parents:

(Circle One) Engaged /Married /Separated /Divorced /Living Together /One or both deceased

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If your parents separated from each other or remarried or entered into new partnerships, how old were you at the time? Separated _____ New Spouse/Partner: Mom _____ Dad _____

If you were adopted, how old were you when placed? _____

If you have siblings, please list below:

Name	Age	Occupation

Other Information

List your strengths _____

List areas you feel you need to develop_____

What do you like most about yourself?_____

_____

What are some ways you cope with obstacles and stress?

_____

_____

What are your goals for therapy? What would you like to accomplish?

_____

_____