Swansea Center for Psychotherapy

25 Market Street, Suite 14 • Swansea, Massachusetts • (508) 379-0150

Name ______________________________

Address ______________________________

City, State, Zip ______________________________

Home Phone: ( ) ______________________ May we leave a message? ❑ Yes ❑ No

Cell/Other Phone: ( ) ______________________ May we leave a message? ❑ Yes ❑ No

Email: ______________________ May we email you? ❑ Yes ❑ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Birthdate ______________________ ❑ Male ❑ Female

Social Security Number ______________________________

Relationship Status ______________________________

Are you currently employed? ______________________________

Are you a student? ______________________________

Referred by ______________________________

PATIENT INSURANCE INFORMATION

Primary Insurance Company ______________________________

ID# ______________________ Group# ______________________

Insurance Company Billing Address (on back of card):

____

Subscriber's Name ______________________________

Subscriber's Address ______________________________

Subscriber's Date of Birth ______________________________

Relationship to Patient ______________________________

Secondary Insurance Company (if applicable) ______________________________

ID# ______________________ Group# ______________________

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

   Poor Unsatisfactory Satisfactory Good Very Good

   Please list any specific health problems you are currently experiencing:

   ____

2. How would you rate your current sleeping habits? (please circle)

   Poor Unsatisfactory Satisfactory Good Very Good

   Please list any specific sleep problems you are currently experiencing:

   ____

3. How many times per week do you generally exercise? _____

   What types of exercise do you participate in? ______________________________________

4. Please list any difficulties you experience with your appetite or eating patterns:

   ____

5. Are you currently experiencing sadness, grief, or depression? ❑ Yes ❑ No

   If yes, for approximately how long? ______________________________________

6. Are you currently experiencing anxiety or panic attacks? ❑ Yes ❑ No

   If yes, when did you begin experiencing this? ____________

7. Are you currently experiencing any chronic pain? ❑ Yes ❑ No

   If yes, please describe:______________________________________

8. Are you currently taking any prescription medication? ❑ Yes ❑ No

   Please list: ______________________________________

   ____

9. Have you ever been prescribed medication for psychological symptoms? ❑ Yes ❑ No
   (for example: anxiety, depression, etc.)

   Please list and provide dates: ______________________________________

   ____

10. Do you drink alcohol more than once a week? ❑ Yes ❑ No

11. How often do you engage in recreational drug use?

    ❑ Daily ❑ Weekly ❑ Monthly ❑ Infrequently ❑ Never

12. Are you currently in a romantic relationship? ❑ Yes ❑ No

13. What significant life changes or stressful events have you experienced recently:

____

____

14. Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

❑ No ❑ Yes - Previous therapist/practitioner: ______________________________

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.)

	Please Circle	**List Family Member**
Alcohol/Substance Abuse	Yes / No	____________
Anxiety	Yes / No	____________
Depression	Yes / No	____________
Domestic Violence	Yes / No	____________
Eating Disorders	Yes / No	____________
Obesity	Yes / No	____________
Obsessive Compulsive Behavior	Yes / No	____________
Schizophrenia	Yes / No	____________
Suicide Attempts	Yes / No	____________

ADDITIONAL INFORMATION:

1. Are you currently employed? ❑ Yes ❑ No

   What is your current employment situation? ______________________________

   ____

   Do you enjoy your work? Is there anything stressful about your current work?

   ____

   ____

   ____

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

   ____

   ____

   ____

3. What do you consider to be some of your challenges?

   ____

   ____

   ____

4. What would you like to accomplish in therapy?

   ____

   ____

   ____