Jill P Smith, MEd, LMHC
1130 Ten Rod Road E-102, North Kingstown, RI 02852
Phone: 401.203.9606 E-mail: jill@jillsmithcounseling.com

Name_____ Date of intake: _____

Date of Birth _____ Phone _____ text ok: Y/N

MEDICAL HISTORY

Current medications being taken:

1. _____ Dosage/Freq_____ Start date_____

Purpose_____

2. _____ Dosage/Freq _____ Start Date_____

Purpose_____ Prescribed by:_____

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital	Mo/Yr	Reason
_____	_____	_____

Do you use recreational drugs? (Circle One) YES NO If no, have you used previously? (Circle One) YES NO

If yes, when did you stop? _____

Type of Drug	How much	How often
_____	_____	_____

Do you drink alcohol? (Circle One) YES NO If no, did you drink previously? (Circle one) YES NO

If yes, please list:

Type of Alcohol	How much	How often
_____	_____	_____

Do you smoke cigarettes or use other forms of tobacco? (Circle One) YES NO

Do you engage in any behavior that leaves you feeling shameful or guilty? (Circle One) YES NO If yes, what behavior?

_____

MARITAL HISTORY

Marital status: ___Single/never married ___Married ___Separated ___Divorced ___Widowed ___Living w/someone

If currently married, when were you married? _____ If living w/someone, how long? _____

Please list your children:

Name	Age	Relationship (biological/step)	Lives with
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY

Please check all information which applies to your biological parents:

MOTHER	FATHER
_____ living	_____ living
_____ deceased	_____ deceased
_____ married	_____ married
_____ divorced	_____ divorced
_____ remarried _____# of times	_____ remarried _____# of times

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? If so, whom?

_____

Where do your parents live?

Mother _____ Father _____

Describe your relationship with your mother while growing up:

_____

Currently:_____

Describe your relationship with your father while growing up:

_____

Currently: _____

List first names and ages of brothers & sisters, including yourself:

Name	Age	Relationship (natural, step, half, etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MENTAL STATUS

Please check any of the following that describe how you have been feeling lately:

_____sad _____anxious _____depressed _____frightened _____guilty _____angry _____ashamed _____aggressive ____resentful
_____worthless ____tearful _____irritable _____confused _____extreme ups/downs _____jealous _____hopeless _____helpless

What activities or hobbies do you participate in?

_____

_____

Do you participate in regular exercise? (Circle One) YES NO Describe:_____

Do you actively relax? (i.e. meditate) _____

How do you cope with stress?

_____

_____

_____

Describe your current working environment:

_____

_____

Have you had any change in sleeping habits? (Circle One) YES NO Describe:

_____

_____

Have you had any change in eating habits? (Circle One) YES NO Describe:

_____

_____

Have you ever **considered suicide** in connection to your **current** problem or in the past? (Circle One) YES NO

Describe:_____

Have you **attempted suicide recently** or in the **past**? (Circle One)YES NO

Describe:_____

Have you had any **homicidal thoughts recently** or in regard to your **current** problem or in the past? (Circle One)YES NO

Describe:_____

What are your opinions or fears regarding therapy?

_____

What do you hope to gain from therapy?

_____

THANK YOU FOR TAKING THE TIME TO FILL THIS OUT AND PLEASE DELIVER IT TO ME AT OUR FIRST VISIT.