This information is held in strict confidence.

DATE: _____

NAME: _____
(Last First Middle)

Date of birth/Age: _____ Where born? _____
Current gender identity _____
Preferred gender pronoun(s) _____
Sex assigned at birth _____
Telephone(s): _____ OK to leave message? _____
Address:_____

****Emergency contact (name, relationship, phone)****

INSURANCE: If relevant, details. Policy name/number, member ID, policyholder's name, deductible, copayment, co-insurance. Is the policy connected with Multiplan, PHCS, Savility? Kindly provide a snap of card front and back of card. *Please note that you are responsible for informing me of all details and changes to your insurance policy.*

*****If you have insurance and chose not use it to pay for psychotherapy with me for whatever reason, kindly write below "I confirm that I have insurance coverage but have declined to use it for payment for therapy services rendered by Jill Edelstein LCSW" and then sign/date next to it.*****

_____
_____
_____

How did you learn about my practice?:

Reason for seeking treatment ("headlines" only; this will be explored further in session):

Psychiatric hospitalization(s)? _____ Date(s)_____
Legal Status (i.e. arrests, convictions, parole), dates_____
_____

SYMPTOMS --Please circle all that apply and note when it began, frequency and severity

Low mood
Irritability
Angry outbursts
Sleep impairment (difficulty falling asleep/staying asleep/waking up too early)
Concentration impairment
Memory impairment/confusion
Appetite impairment
Weight gain/loss (unintended)
Muscle fatigue
Feels like I'm walking very slowly/laboriously
Difficult-to-control worrying about the past/future
Feeling worthless, hopeless about the future
Not enjoying (or enjoying to a lesser degree) previously enjoyed activities or relationships
Anxious
Gastrointestinal issues
Heart racing
Profuse sweating
Shortness of breath
Dizziness
Fogginess, feeling "spaced out"
Watching my life like it's a movie but I'm not a participant
Hearing or seeing things that others do not hear or see
Avoiding people/places/things/activities
Intrusive thoughts (images/thoughts spring into your mind on their own schedule, by surprise)
Irrational fears
Impulsive or compulsive eating/shopping/sex (including binging/purging)
Hearing/Vision problems
Dental problems
Premenstrual/gynecological issues
Thyroid imbalance
Anemia
High blood pressure
Heart problems
Other _____

Have you ever attempted suicide? Y N

Date(s)_____

Circumstance(s)/trigger(s)

Have you ever, or do you now, cut yourself or engage in other self-harming behaviors (e.g.hitting self, head banging)? Y N

Circumstances(s)/trigger(s)

PHYSICAL HISTORY & WELLNESS

When was your most recent physical? _____
Did your physical include EKG and blood work? _____
Are you being seen by a psychiatrist for medication monitoring? _____
Doctor(s') name(s), telephone number(s) _____
_____
_____
Are you going through perimenopause or menopause? Y N

Please list any **serious** illness, disability, surgeries and/or non psychiatric hospitalizations. Include dental procedures. **Also note chronic conditions** (i.e. less acute, ongoing, intermittent), history and current status.

Please list all current **psychiatric and non-psychiatric** medications as well as supplements (including dosage) taken, for what, and for how long. Note whether these are being monitored by a physician, psychiatrist or other provider.
_____
_____
_____
_____
_____
Do you exercise? If so please note what kind(s) and how often.

Do you have a religious and/or spiritual practice? Same or different than what, if anything, you were born into? Describe briefly.

Do you have social supports (friend circle(s), social and/or faith communities)? Please note.

PSYCHOLOGICAL HISTORY

Have you been in therapy before? Y N

If yes, please indicate dates of and reasons for treatment. For what reason(s) did you terminate?

Do you use alcohol, marijuana or other substances? Y N

Please list which, when you began to use each, how often and quantity.

Do you now, or have you ever, had concerns or issues with your eating, body weight/size? Y N

If so, please note when it began, history of and how it showing up now.

Do you now, or have you ever, had concerns or issues with other compulsions such as shopping, pornography, sexual acting out, extreme/dangerous risk taking, gambling or shoplifting? Y N

Please describe.

Are you aware of mental illness, alcohol/substance abuse, violence or strange behavior in your family of origin? Y N

Please describe.

RELATIONSHIPS & FAMILY STATUS

(circle all that apply)
single
married
significant long-term relationship
polyamorous
separated
divorced
widowed/widower
other _____

If applicable, are you satisfied with your romantic relationship(s)? Please describe.
_____
_____

Any concerns about sexuality, sexual orientation, gender identity? If yes, please describe
_____
_____

Are you currently working with gender identity? Y N
Please note that an additional questionnaire for gender-related concerns including transition will be provided as appropriate.
_____
_____

Do you have children, whether by birth, adoption or other circumstance? Please list ages and note whether child is adopted, fostered or residing within a kinship or other arrangement. Difficulty conceiving? Miscarriage/other pregnancy loss? History of same in family of origin (whether biological or otherwise)?

family of origin

Any noteworthy family events (deaths, injuries, unemployment, e.g.) dynamics that have impacted you? An example might be, "my mother did not talk to her mother throughout my childhood." This could include cultural dimensions such the impact of immigration, racism or other bias.

Were you raised by your biological parents? Y N
If not, please describe situation/circumstances.

Siblings? Y N
Raised with siblings? Y N
Please note ages and birth order (including yourself); describe relationships as a child and now

Parents/caretakers' ages, occupations.

Do you have a "chosen" family? If yes, please describe.

Did you have friends as a child? Best friend(s)? Groups? Easy/difficult to make/maintain friendships now? Please describe.

other

EDUCATION

How far did you go in your education or other training? Please note degrees, special areas of study or interest.

Are you satisfied with your level and area of education and/or other training? Y N
If no, please elaborate.

EMPLOYMENT

Occupation(s) or what trained for _____

Present employer _____

Position _____

Are you satisfied with this position? Y N

If yes, what do you like best?

If no, what aspects make it unpleasant?

How do you support yourself financially (job income, benefits, contributions from family, other)?

Please note days and times you are available for regular weekly therapy appointments. My schedule is currently Monday through Thursday. Kindly note the earliest you could arrive at my office.

MON _____
TUES_____
WEDS_____
THURS_____

What are your expectations of therapy and of your therapist?

I*s there anything else you think I should know?*

MPORTANT: Please note that no private practitioners, hospitals or agencies will be contacted without your authorization. Any requested information will be held in strictest confidence. Please sign release forms as appropriate.