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Modern Wellness Psychotherapy & Healing

333 North Dobson Road, Suite 5

Chandler, AZ 85224

(480) 280-8888 | www.mod-well.com

Patient Information:

Name: ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Service Access:

Do you have health insurance? Yes or No

Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­

Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plan Type (PPO, HMO, Open Access, ect)

Birthday of primary insurred: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you insured by any other health plan? Yes or No

Have you ever received psychotherapy services before? Yes or NO

If yes, when was the last time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Demographics:

Gender: Male or Female

Gender Identity:

Sexual Orientation: Heterosexual, Bisexual, Gay/Lesiban, Transgender, Not sure/Questioning

Are you disabled? Yes or No

Marital Status: Single, Living together, Married, Divorced, Separated, Widowed

Ethnicity: Caucasian, Latino, Asian-America, African-American, Native American/Alaskan Native, Bi-

Racial, Multi-Racial, or International

Health Information:

Have you had any serious accidents, injuries or illnesses? Yes or No. If yes, please specify:

Do you have any physical disabilities or learning disabilities? Yes or No. If yes, please specify:

Are you presently taking any medications? If “yes” please list:

## Family Background:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Name | Age (or Deceased) | Level of Education | Occupation |
| Father: |  |  |  |  |
| Mother: |  |  |  |  |
| Siblings:(1) |  |  |  |  |
| (2) |  |  |  |  |
| (3) |  |  |  |  |
| (4) |  |  |  |  |
| Have your parents ever been divorced? | | Yes / No | If yes, when:Your age: |  |
| Has your father ever had a problem with alcohol or drugs? | | Yes / No | If yes, when:What substance? |  |
| Has your mother ever had a problem with alcohol or drugs? | | Yes / No | If yes, when: What substance? |  |

## Relationship Background: (Skip this section if you have never been in a long-term relationship)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Name | Age (or Deceased) | Level of Education | | Occupation |
| Spouse: |  |  |  | |  |
| Partner: |  |  |  | |  |
| Children:(1) |  |  |  | |  |
| (2) |  |  |  | |  |
| (3) |  |  |  | |  |
| (4) |  |  |  | |  |
| (5) |  |  |  | |  |
| (6) |  |  |  | |  |
| Total length of relationship: | | Years dated: | | Years married: |  |
| Have you ever been separated or divorced? | | Yes / No | If yes, when: | |  |
| Has your spouse/partner ever had a problem with alcohol or drugs? | | Yes / No | If yes, when: What substance? | |  |

Current List of Concerns:

Below is a list of concerns commonly experienced by adults. To facilitate the best assessment of your current situation, please circle the number indicating the degree to which each item ***is presently a concern*** for you using the following scale:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Not at all  0 | A little bit  1 | Moderately  2 | Quite a bit  3 | Very much  4 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. Dealing with stress or pressure | 0 | 1 | 2 | 3 | 4 |
| 1. Adjusting to the school, work, or living environment | 0 | 1 | 2 | 3 | 4 |
| 1. Feeling depressed, sad, or down | 0 | 1 | 2 | 3 | 4 |
| 1. Establishing or changing a career direction | 0 | 1 | 2 | 3 | 4 |
| 1. Death or illness of a significant person | 0 | 1 | 2 | 3 | 4 |
| 1. Performance anxiety, time management | 0 | 1 | 2 | 3 | 4 |
| 1. Difficulties related to sexual identity or sexual orientation | 0 | 1 | 2 | 3 | 4 |
| 1. Relationships with family members (parents, siblings, children, relatives) | 0 | 1 | 2 | 3 | 4 |
| 1. Feeling anxious, fearful, worried, or panicky | 0 | 1 | 2 | 3 | 4 |
| 1. Feeling unmotivated, procrastination, or difficulty concentrating | 0 | 1 | 2 | 3 | 4 |
| 1. Feeling irritable, tense, angry, or hostile | 0 | 1 | 2 | 3 | 4 |
| 1. Money, finances | 0 | 1 | 2 | 3 | 4 |
| 1. Feeling lonely, isolated, or uncomfortable with others | 0 | 1 | 2 | 3 | 4 |
| 1. Values, beliefs, religion, or spirituality | 0 | 1 | 2 | 3 | 4 |
| 1. Past sexual experiences (sexual abuse, incest, unwanted sexual behavior) | 0 | 1 | 2 | 3 | 4 |
| 1. Low self-esteem or self-confidence | 0 | 1 | 2 | 3 | 4 |
| 1. Legal matters | 0 | 1 | 2 | 3 | 4 |
| 1. Someone else’s habits or behaviors | 0 | 1 | 2 | 3 | 4 |
| 1. Unwanted/out-of-control behaviors or habits | 0 | 1 | 2 | 3 | 4 |
| 1. Problems with assertiveness or shyness | 0 | 1 | 2 | 3 | 4 |
| 1. Sleep problems | 0 | 1 | 2 | 3 | 4 |
| 1. Rape, sexual assault, or sexual harassment | 0 | 1 | 2 | 3 | 4 |
| 1. Eating problems (bingeing, restricting, low appetite, vomiting, laxative use, etc.) | 0 | 1 | 2 | 3 | 4 |
| 1. Relationships with romantic partner/spouse | 0 | 1 | 2 | 3 | 4 |
| 1. Physical health problems (headache, pain, fainting, injury, fatigue, etc.) | 0 | 1 | 2 | 3 | 4 |
| 1. Sexual matters (pregnancy, sexually transmitted disease, sexual functioning, etc.) | 0 | 1 | 2 | 3 | 4 |
| 1. Urge or plan to harm another person | 0 | 1 | 2 | 3 | 4 |
| 1. Relationships with work colleagues or boss | 0 | 1 | 2 | 3 | 4 |
| 1. Suicidal thoughts and feelings | 0 | 1 | 2 | 3 | 4 |
| 1. Racial, sexual, or other discrimination | 0 | 1 | 2 | 3 | 4 |
| 1. Feelings of guilt or self-criticism | 0 | 1 | 2 | 3 | 4 |
| 1. Weight or body image problems | 0 | 1 | 2 | 3 | 4 |
| 1. Your use of alcohol, drugs, or other substances | 0 | 1 | 2 | 3 | 4 |

What is the **primary reason you are seeking counseling** at this time?

How well are you getting along emotionally at this time? Very Well, Fairly Well, Adequately, Not Too Well, Poorly

Counseling Referral:

How did you hear about our psychotherapy services?