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	A little bit	Moderately	Quite a bit	Very much
0	1	2	3	4

1. Dealing with stress or pressure	0	1	2	3	4
2. Adjusting to the school, work, or living environment	0	1	2	3	4
3. Feeling depressed, sad, or down	0	1	2	3	4
4. Establishing or changing a career direction	0	1	2	3	4
5. Death or illness of a significant person	0	1	2	3	4
6. Performance anxiety, time management	0	1	2	3	4
7. Difficulties related to sexual identity or sexual orientation	0	1	2	3	4
8. Relationships with family members (parents, siblings, children, relatives)	0	1	2	3	4
9. Feeling anxious, fearful, worried, or panicky	0	1	2	3	4
10. Feeling unmotivated, procrastination, or difficulty concentrating	0	1	2	3	4
11. Feeling irritable, tense, angry, or hostile	0	1	2	3	4
12. Money, finances	0	1	2	3	4
13. Feeling lonely, isolated, or uncomfortable with others	0	1	2	3	4
14. Values, beliefs, religion, or spirituality	0	1	2	3	4
15. Past sexual experiences (sexual abuse, incest, unwanted sexual behavior)	0	1	2	3	4
16. Low self-esteem or self-confidence	0	1	2	3	4
17. Legal matters	0	1	2	3	4

18. Someone else's habits or behaviors	0	1	2	3	4
19. Unwanted/out-of-control behaviors or habits	0	1	2	3	4
20. Problems with assertiveness or shyness	0	1	2	3	4
21. Sleep problems	0	1	2	3	4
22. Rape, sexual assault, or sexual harassment	0	1	2	3	4
23. Eating problems (bingeing, restricting, low appetite, vomiting, laxative use, etc.)	0	1	2	3	4
24. Relationships with romantic partner/spouse	0	1	2	3	4
25. Physical health problems (headache, pain, fainting, injury, fatigue, etc.)	0	1	2	3	4
26. Sexual matters (pregnancy, sexually transmitted disease, sexual functioning, etc.)	0	1	2	3	4
27. Urge or plan to harm another person	0	1	2	3	4
28. Relationships with work colleagues or boss	0	1	2	3	4
29. Suicidal thoughts and feelings	0	1	2	3	4
30. Racial, sexual, or other discrimination	0	1	2	3	4
31. Feelings of guilt or self-criticism	0	1	2	3	4
32. Weight or body image problems	0	1	2	3	4
33. 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?