6703 Germantown Avenue
Philadelphia, PA 19119
(267)245-6146
hnsawyer@lifefirsttherapy.com
www.lifefirsttherapy.com

I look forward to working with you! This information is confidential information. Please bring to your first session!

Name:_____

Gender:_____ AGE: _____ DOB:_____

Street Address: _____

City, State, ZIP _____

Phone #:_____Cell phone #_____

Email:_____

May I text, call, or leave a message at this number &/or email:
Email **Yes** ____ **No** ____ Phone **Yes** ____ **No** ____
NOTE Email/text correspondence is not guaranteed as a confidential method of communication. If you choose to use it, please limit to details like scheduling and know that by checking the above boxes, you are allowing its use. ***Please Initial here:**_____

Children: **Yes** ____ **No** ____ Ages/Gender: _____

Marital Status
- ☐ Never Married
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Living w/partner

Special Needs
- ☐ Mobility Aid:
- ☐ Language Interpreter: _____
- ☐ Hearing Aid: _____
- ☐ Vision Needs: _____
- ☐ Literacy Needs: _____

Ethnicity
- ☐ Black
- ☐ Hispanic
- ☐ American Indian
- ☐ Asian/Pacific Islander
- ☐ Caucasian
- ☐ Other

Any relationship issues: **Yes** ____ **No** ____ Are you currently employed? **Yes** ____ **No** ____

Is faith an important part of your life? **Yes** ____ **No** ____

If so, what is your religious/spiritual preference?

_____

Participant's Name:_____

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Presenting Behaviors/Concerns

Briefly describe 1-2 primary concerns that bring you to Life First Therapy.

_____

_____

_____

Briefly describe 1-2 goals you would like to achieve by coming to treatment.

_____

_____

_____

_____

Educational History

Did you graduate from high school? Yes _____ No _____
If not, what was the last grade you completed? _____
Did you obtain a GED? Yes _____ No _____
Are you currently attending college? Yes _____ (**if yes, skip the next question**) No _____
Have you ever attended college classes? Yes _____ No _____
Did you graduate? Yes _____ No _____
Have you been told you have a learning difference/disability? Yes _____ No _____ Don't know _____
If yes please describe: _____
_____
_____
Have you ever been in special education classes? Yes _____ No _____ Don't know _____
If yes what grades? 9th _____ 10th _____ 11th _____ 12th _____

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Mental Health Status/History

Have you ever experienced any of the following:

Symptom:	Current	Past	Symptom:	Current	Past
Audio hallucinations	☐	☐	Phobia	☐	☐
Visual hallucinations	☐	☐	Memory loss	☐	☐
Tactile hallucinations	☐	☐	Paranoia	☐	☐
Hopelessness	☐	☐	Binge/purging/restricting	☐	☐
Depression	☐	☐	Disorientation	☐	☐
Obsessive thoughts	☐	☐	Flashbacks	☐	☐
Compulsive thoughts	☐	☐	Panic attacks	☐	☐
Anxiety/nervousness	☐	☐	Self-mutilation/cutting	☐	☐
Domestic Violence/Abuse	☐	☐	Eating Disorders	☐	☐
Schizophrenia	☐	☐	Borderline Personality	☐	☐
Bi-Polar Disorder	☐	☐	Disorders		

Do you have or have you ever had a mental health diagnosis? Yes___ No___
If yes, what? _____

Has anyone in your family ever had a mental health diagnosis? Yes ____ No ____
If yes, please describe:

_____
_____
_____

Are you currently receiving mental health treatment at another facility? Yes___ No___
Facility_____ Telephone #: _____
Have you received treatment for mental health reasons in the past? Yes __ No ___ Unsure ___
Were you ever prescribed medications for mental health issues? Yes ____ No ____ Unsure _____

IF YES, COMPLETE GRID:

Drug Prescribed	Dosage Prescribed	Frequency of Use	Route of Administration	Date Prescribed	Physician Prescribing	Effective – Yes or No

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Suicide/Homicide Assessment

Are you currently feeling suicidal? Yes _____ No _____
If yes, do you have a plan? Yes___ No___
Explain:

_____
_____
_____

Are you willing to complete a contract for safety? Yes ____ No ____
Have you ever had thoughts of hurting yourself? Yes___ No___
If yes, describe:_____

COMPLETE GRID, IF APPLICABLE:

SUICIDE ATTEMPT HISTORY Have ever attempted suicide: Yes ☐ No ☐				
Year	Precipitating Factors	Method	Drug-Related?	Hospitalized?

Have you ever had thoughts of hurting others? Yes___ No___ If yes, describe:

_____
_____
_____

Medical History

Do you have any of the following:

Medical Conditions:	Current	Ever		Current	Ever
Asthma	☐	☐	Heart condition	☐	☐
Cancer	☐	☐	Hepatitis A B C	☐	☐
Cirrhosis	☐	☐	High Blood Pressure	☐	☐
Diabetes	☐	☐	Seizure Disorder	☐	☐
STDs	☐	☐			

Participant's Name:_____4

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Any physical challenges? Yes ___ No ___
If yes, please describe:

Have you ever been prescribed medications or used drugs or alcohol to cope? Yes ___ No ___
If yes, describe:

Personal History

How do you usually cope with stress?

What do you consider to be some of your strengths or areas in your life that are going well?

What do you consider to be some of the areas you need to improve?

What do you hope to accomplish out of your time in therapy?

What may happen if you don't change/address the issues that brought you here?

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How will you know therapy is working? Is there anything specific you want as an outcome?

Do you get into arguments or fights with family, friends, or co-workers? Yes ___ No ___ Unsure ____
If yes, please explain why and how you resolve the conflict:

Do you consider yourself to be a violent person? Yes ___ No ___ Unsure ____
If yes or unsure, explain:

Do other people consider you to be a violent person? Yes ___ No ___ Unsure ____
If yes or unsure, explain:

Is there anything else I should know about your story, history or situation?

This form will be securely stored in client's clinical file and updated upon request at any time.

Participant's Name:_____6