



“Make Living Your Priority”

2031 66th Avenue Unit #14176

Philadelphia, PA 19138

(267)598-5433

hnsawyer@lifefirsttherapy.com

www.lifefirsttherapy.com

Name: _____

Gender: _____ AGE: _____ DOB: _____

Street Address: _____

City, State, ZIP _____

Phone: _____ Cell: _____

Email: _____

Emergency Contact: _____ Phone: _____

May I text, call, or leave a message at your 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 1-3 primary concerns that brings you to therapy.

Briefly describe 1-3 goals you would like to achieve by coming to therapy.

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 _____

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 _____

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 _____

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Mental Health Status/History

Have you ever experienced any of the following:

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

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 ___

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IF YES TO PREVIOUS QUESTION, COMPLETE GRID:

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

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: _____

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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:

<u>Medical Conditions:</u>	<u>Current</u>	<u>Ever</u>		<u>Current</u>	<u>Ever</u>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart condition	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A B C	<input type="checkbox"/>	<input type="checkbox"/>
Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>
STDs	<input type="checkbox"/>	<input type="checkbox"/>			

Any physical challenges? Yes ___ No ___

If yes, please describe:

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

Personal History

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:

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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 to therapy?

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How will you know therapy is working?

Is there anything specific you want as an outcome? Yes ___ No ___ Unsure ___

If yes, please explain:

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

Participant's Name: _____