



JULIA BARRY
PSYCHOLOGIST

Please fill in the information below and bring it with you to your first session. Please note: information provided on this form is protected as confidential information.

Personal Information:

Name: _____ Date: _____

Parent/Legal Guardian (if under 18): _____

Address: _____

Home Phone: _____ May I leave a message? Yes No Cell/Work/

Other Phone: _____ May I leave a message? Yes No

Email: _____ May I contact you by email? Yes No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

DOB: _____ Age: _____ Gender: _____

Gender Pronouns: _____ Sexual Orientation: _____

Marital Status: Never Married Domestic Partnership Married Separated Divorced Widowed

Children/ Ages _____

With whom do you live? Spouse _____ Parents _____ Other _____

List 2 people to be contacted in case of emergency:

Name/Relationship: _____

Name Relationship: _____

Do you have any pets? _____

Driver's License _____ Occupation _____

Approximate Yearly Income _____

Education (List Degrees) _____

Referred by _____ Permission to acknowledge? _____



Health History:

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? No Yes, previous therapist/practitioner: _____

Length of therapy? _____

Current Physician's Name/Phone Number _____

Are you currently taking any prescription medication? Yes No If yes, please list:

Have you ever been prescribed psychiatric medication? Yes No If yes, please list and provide dates:

Current Psychiatrist's Name /Phone Number (If applicable)

Have you ever been hospitalized for psychological reasons or drug dependency?

Yes No If yes, please describe: _____

General and Mental Health Information:

How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing: _____

How would you rate your current sleeping habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____



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Please list any difficulties you experience now or in the past with your appetite or eating problems:

Are you currently experiencing overwhelming sadness, grief or depression? No Yes

If yes, for approximately how long? _____

Are you currently experiencing any thoughts of self harm or suicide? No Yes

If yes, please describe _____

Are you currently experiencing anxiety, panics attacks or have any phobias? No Yes

If yes, when did you begin experiencing this? _____

Are you currently experiencing any chronic pain? No Yes If yes, please describe:

Do you have a history of recreational drug use? No Yes

If yes, please describe _____

Do you drink alcohol more than once a week? No Yes

If yes, how often _____

How often do you engage in recreational drug use?

Daily Weekly Monthly Infrequently Never

Are you currently in a romantic relationship? No Yes

If yes, for how long? _____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?

On a scale of On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your sexual satisfaction?



Family History & Childhood Experience:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

Please Circle and List Family Member:

Alcohol/Substance Abuse yes / no _____

Anxiety yes / no _____

Depression yes / no _____

Domestic Violence yes / no _____

Eating Disorders yes / no _____

Obesity yes / no _____

Obsessive Compulsive Behavior yes / no _____

Schizophrenia yes / no _____

Suicide Attempts yes / no _____

Parents: *Name, age; if deceased, year and cause of death, occupation, personality. Brief statement about the relationship.*

Father: _____

Mother: _____

Step-parents and/or birth parents: _____



Siblings: *Name and age; if deceased, age and cause of death. Brief statement about the relationship*

Family medical history: *Describe any medical illness that runs in the family.*

Describe your childhood in general: *Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral problems, abusive/alcoholic parents.*

If parents divorced, your age at the time: _____. *Describe how it affected you at the time.*

Past partnerships/marriages: *Years together, names & statement about the nature of the relationship.*

Children: *Include step-, grand-, adopted and children by birth. Names, ages & brief statement on your relationship. If adopted, at what age was child placed? Domestic or foreign adoption? Open or closed adoption?*



Trauma History:

Have you ever experienced any of the following events? If yes please indicate your age at the time of the event, and any other details you wish to provide. Please feel free to use back of paper if needed. Indicate N/A next to each item that does not apply to you in any way.

Childhood neglect:

Being bullied:

Childhood physical abuse:

Natural disaster:

Childhood sexual abuse:

Death of a loved one:

Childhood loss of a parent either by death or divorce:

Witnessed another's suicide or murder:

Rape/sexual assault:

Experienced a suicide attempt:



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Physical assault:

Military combat:

Domestic violence:

Have/or have had a life -threatening illness:

Community violence:

Transportation accident:

Additional Information:

Are you currently employed? No Yes If yes, what is your current work situation?

Do you enjoy your work? Is there anything stressful about your current work?

Describe the quality of your relationships with your friends and community: *Describe quality, frequency of contact, activities.*

Do you consider yourself to be spiritual or religious? No Yes If yes, describe your faith or belief:



Presenting problem: *Please be as specific as you can. What brings you to therapy?*

When did it start? How does it affect you? Who is involved?

How severe is the problem? mild ___ moderate ___ severe ___ very severe ___

What significant life changes or stressful events have you experienced recently? _____

Resources: things, places relationships or activities that

1. *calm you down* _____

2. *engage you* _____

3. *bring you pleasure* _____

4. *help you sleep* _____

When you have a good day, what makes it better than other days? _____

Who in your life have you felt closest to and why?

Who or what do you rely on for strength and support?

In what environments do you feel the safest/ most comfortable (nature, etc.)



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What do you consider to be some of your strengths?

What do you consider to be some of your greatest areas of challenge?

What would you like to accomplish out of your time in therapy?

What gives you the most pleasure or joy in your life? _____

What do you do to relax, have fun, take care of yourself? _____

What are your main worries and fears? _____

What are your most important hopes or dreams? _____

Please add on a separate page any other information you would like me to know about you and your situation.