**History, Concerns, Goals**

Current symptoms and/or concerns_____

Date of your last doctor appointment:_____

Major medical injuries, illnesses, or surgeries_____

_____

Current medications you are taking (name, dosage, prescribing MD)_____

Psychiatric medications you have taken in the past (name, dosage, prescribing MD, start/stop date_____

Please list any substances you use (alcohol, marijuana, caffeine, tobacco, heroin, psychedelics, methamphetamine, etc):_____

Please list past therapists and/or psychiatric hospitalizations:

_____

Psychiatric disorders in immediate or extended family_____

Describe your current support system (family, friends, organizations, etc)

_____

Do you ever have thoughts about hurting yourself or others? Yes ___ No _____

If yes, please describe_____

What are your goals for therapy??

1)_____

2)_____

3)_____