Gretchen M. Sanders, LCSW
3724 Jefferson Street, Suite 207
Austin, Texas 78731
(737) 204-6469

Contact Information

Name_____ Age _____ DOB_____

Address_____ City_____ Zip_____

Phone_____ E-mail_____

May I leave a voicemail at this number? Y/N May I text this number? Y/N

Emergency Contact: _____ Phone _____

Relationship to you _____

How were you referred to me?_____

Description of presenting problem

Please describe what brought you into counseling.

How long has this been a significant problem for you?

In the past, what has been helpful to you in dealing with this problem?

How would you estimate the severity of the problem at this time?

Mild *Moderate* *Serious* *Severe*

Do you feel that you are/have been at risk of hurting yourself at this time or in the past?

Never *Sometimes* *Often* *Always*

Have you ever been in counseling/therapy before? Y/N

If so, please say how that experience was for you.

Medical History and Hospitalizations

Please list any significant past or current health, medical or psychiatric issues.

Dates **Problem and Treatment** **Hospitalized (Y/N)** **Duration**

_____

_____

_____

Medications and Substances Used

Medication **Dosage** **Person Prescribing** **Duration** **Helpful (Y/N)**

_____

_____

_____

How many alcoholic beverages would you say you consume in a week? _____

Is this a problem for you?_____

If applicable, list other substances used (including amount and frequency)

_____

Relationships/Family Information

Are you: single _____ married_____ living together_____

Children Y/N Ages _____

If you are in a relationship, would you describe this relationship as supportive? Y/N

Is there anything else you would like me to know before we begin?

Signature _____ **Date** _____