

**General Information:**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Contact Number: \_\_\_\_\_ Email: \_\_\_\_\_

Is it all right to text you?  yes  no Is it alright to email you?  yes  no

**Current Mental Health:**

Are you currently feeling depressed?  yes  no

Are you currently feeling anxious?  yes  no

Are you concerned with the nature of your thoughts?  yes  no

Are you currently taking any medication?  yes  no

If yes, which one(s): \_\_\_\_\_

-

Who is your prescribing psychiatrist? \_\_\_\_\_

Phone Number: \_\_\_\_\_

Describe in your own words the challenges that bring you in today? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What are the treatment goals that you would like to pay most attention to? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_