Confidential Information Form

Grace Layton, LLC. 8310 Allison Pointe Blvd., Indpls, IN Suite 203C 46250. Ph. 317-622-6544

Name: _____

How did you find my name (referral, internet, phone book, other)**?** _____

If referred, may I send the referral a thank you? Yes / No

Therapy Needs

Reason for Seeking Counseling: _____

_____

Goal of Therapy (how will you know you ready to end therapy?)_____

_____

When did the symptoms begin and how have the symptoms changed over time?_____

_____

_____

Any past therapy? Yes ___ No ___ If yes, name of previous therapist: _____

When? _____ Length or # of sessions? _____

Danger to Self:

☐ **None**
☐ ***Previous History only***
☐ ***Previous History and Current***
☐ ***Current Only***

☐ Thoughts of Suicide
☐ Preoccupation with death
☐ Family history of suicide
☐ Self Mutilation
☐ Increased agitation
☐ Recent will or giving away possessions
☐ Threats suicide
☐ Suicide gesture
☐ Inability to care for self
☐ Easy Access to firearms
☐ Increase in symptoms
☐ Recent/anticipated stressors or losses
☐ Plan for suicide
☐ Suicide attempts
☐ Unsafe Sex
☐ Recent Suicide Note
☐ Male over 60

Protective Factors:

☐ **None**

☐ Positive religious beliefs
☐ Good physical health
☐ Hope / Future orientation
☐ Coping / Problem solving skills
☐ Supportive relationships
☐ Employment skills / security

Danger to Others:

☐ **None**
☐ ***Previous History***

☐ Thoughts to harm others
☐ Attempts to harm others
☐ Hurt animals
☐ Neglect of dependents
☐ Threats to harm others
☐ Felt like killing someone
☐ Arson
☐ Risky sexual behavior
☐ Plan to harm others
☐ Killed someone
☐ Reckless driving
☐ Gangs/Sects

Substance Use:

Do you drink or use any other drugs? If so explain frequency and quantity.__

_____

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Status and length of time (circle all that apply) :

Married _____ Separated _____ Divorced _____ Single_____
Widowed _____ Committed to Someone _____ Employed Full-time_____
Employed Part-time_____ Full-time Student_____ Part-time Student _____

Employment Information

Current Employer: _____ Hire Date/Year: _____

Title/Position: _____

Approximate Hours Worked Per Week: _____ Does your job satisfy you? _____

Military Background: Yes / No (if yes, please explain):_____

_____

Medical Information

Primary Care Physician: _____ Psychiatrist: _____

Have you been diagnosed with any mental health disorders Yes / No ? If yes please state date of diagnosis and current medications used to treat diagnosis:_____

_____

Have you previously been prescribed psychiatric medication other than those listed above? Yes / No ? If yes, explain (what was the medicine, how did it work for you, when and how long you took it, why did you stop taking it): _____

_____

_____

Other medical diagnosis and current medications (include dosages, what medication is prescribed for, when did you start taking medication, how frequently taken, and time of day it is taken). Also please note any other medical complaints not medicated:_____

_____

_____

Do you feel you are in need of medication that is not currently prescribed to you? Yes / No

If yes, please explain: _____

General Well-Being

How would you rate your current **sleeping** habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

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

_____

How often do you generally **exercise**? _____ What types of exercise to you participate in?

_____

Please list any difficulties you experience with your **appetite** or eating patterns: _____

_____

Family

Family Members Living in Household (continue at bottom of form if necessary):

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Please list any of your children not living with you (include ages): _____

_____

List any **family history of medical or mental health** issues: _____

_____

Spirituality

Will spirituality be a part of your therapeutic journey or healing? Yes / No Please explain: ___

_____

If you currently attend place of worship, where do you attend?_____

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Symptom Checklist:

☐ Development of emotional or behavioral symptoms in response to an identifiable stressor.
☐ Depressed mood more days than not OR ☐ Sadness at times
☐ Anxiety more days than not OR ☐ Stressed out or anxious at times
☐ Worry is difficult to control
☐ Impairment in social or occupational (academic) functioning
☐ Disturbance in your usual conduct
☐ Irritability
☐ Restlessness or feeling keyed up or on edge
☐ Difficulty concentrating, mind going blank, or indecisiveness nearly everyday
☐ Muscle tension
☐ Loss of interest or pleasure in all, or almost all, activities
☐ Significant weight loss or gain (5% in one month) when not dieting
☐ Decrease or increase in appetite
☐ Insomnia or hypersomnia nearly every night
☐ Fatigue or loss of energy nearly every day
☐ Feelings of worthlessness nearly everyday
☐ Feeling excessive or inappropriate guilt nearly every day
☐ Recurrent suicidal thoughts
☐ Hopelessness
☐ Symptoms have been present less than 6 months OR ☐ Symptoms have been present 6 months or longer
☐ Other, please explain: _____

_____

_____

Therapist Section Only

Axis I Diagnostic Impression: _____

_____

_____

_____

_____

_____