Annie M. Garry, LCSW

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Client Name:			
Street Address:			
City:		State:	Zip:
Birth Date:	Age:	Gender: __ Male __Female	
Home Phone:		Work Phone:	
Cell Phone:		Other Phone:	
Employer/School:			

Parent/Guardian Name (for clients under age 18):			
Street Address:			
City:		State:	Zip:
Birth Date:	Social Security #:		
Home Phone:	Work Phone:		
Cell Phone:	Other Phone:		
Employer:			

Why are you are seeking treatment:

Check all symptoms/problems you have experienced during the past 60 days:

- □ Sleep changes
- □ Appetite changes
- □ Weight changes
- □ Stress
- □ Eating disorder
- □ Agitation
- □ Anger
- □ Violence
- □ Depressed mood
- □ Mania
- □ Mood swings
- □ Suicidal thoughts/behaviors
- □ Thoughts of hurting others
- □ Work problems
- □ School problems
- □ Impulsive behavior
- □ Poor concentration/attention
- □ Hyperactivity
- □ Memory problems
- □ Runaway risk
- □ Family issues
- □ Parenting issues
- □ Couple issues
- □ Dissociative behavior
- □ Chronic pain
- □ Self-mutilation/cutting
- □ Paranoid thoughts
- □ Disorganized thoughts
- □ Obsessive thoughts
- □ Compulsive behavior
- □ Delusions
- □ Hallucinations
- □ Tics/Tourette's
- □ Substance abuse
- □ Panic attacks
- □ Anxiety
- □ Sexual orientation concern
- □ Spiritual/religions concerns
- □ Other:_____

List current medical conditions/illnesses:

List current medications (include dosage and frequency):

Name of current medical provider(s):

Primary Care Physician: _____

Phone Number: _____

Additional Provider: _____

Phone Number: _____

Have you ever had a head injury or seizure? □ Yes □ No

If Yes, Describe:

Please check all substance you have used in the past 30 days:

□ Tobacco	□ Tranquilizers	□ Heroin
□ Alcohol	□ Sleeping pills	□ Cocaine/Crack
□ Marijuana	□ Pain killers	□ Amphetamines/Speed
□ Methadone	□ LSD/PCP/Ecstasy	□ Inhalants

□ Other:_____

Have you ever been treated for drug/alcohol problems? □ Yes □ No

If Yes, When? _____

Where? _____

Have you ever engaged in any other addictive behavior (e.g. Food, gambling, sex, shopping, etc.)?

If Yes, Describe:

Describe any current or relevant legal problems and concerns:

What is your occupation?

Describe any concerns related to your employment?

What is your current or highest level of education? _____ Grade □ Some college/technical school

□ College/technical degree □ Graduate degree □ Post graduate degree □ Other: _____

Describe any educational or school concerns:

Are there any developmental problems or concerns? □ Yes □ No

If Yes, Describe:

Have you ever had any concerns regarding childbirth complications? □ Yes □ No

List name(s) and relationship of anyone in your family who has a history of psychological, developmental, emotional, behavioral, or drug/alcohol problems?

How would you describe your support network? □ Good □ Fair □ Poor

***I agree to pay all fees and amounts for any and all psychotherapeutic services provided by Annie Garry, LCSW. I understand I will be responsible for paying a fee if I cancel an appointment with less than 24 hours advance notice.*

_____ _____

Client Signature Date

_____ _____

Parent or Guardian's Signature *(if client is under age 18)* Date