YOGA MIND
psychotherapy
BLENDING THE ART OF YOGA AND THE SCIENCE OF PSYCHOTHERAPY
TO CREATE BALANCE BETWEEN HEART, MIND AND BODY

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New Client Information

Name: ___________________________________ **Age:** _____ **Date of Birth:** ___/___/____
Date:___/___/____

Address: ____ City___________________ State_______
Zip_________

Home Phone: ________________________ May I contact you or leave a message: ❑No ❑Yes

Cell Phone: __________________________ May I contact you or leave a message: ❑No ❑Yes

Email Address: ____ May I e-mail you: ❑No ❑Yes

Emergency Contact:
In case of an emergency please notify:

____

Emergency Phone Number(s): ______________________ Relationship: ________________________

Referred to Therapy by:
❑ Self ❑Parent/Family ❑Friend ❑ Counselor/Psychologist
❑Other:____

Demographic Information

Gender: ❑ Male ❑ Female ❑ Transgender ❑ GenderQueer ❑Other:
____

What race , ethnicity, or culture(s) do you identify with?

____

____

____

Sexual Orientation:
❑ Heterosexual ❑ Gay/Lesbian ❑ Bisexual ❑ Queer ❑ Fluid ❑ Questioning ❑
Other:________________

Relationship Status:
❑ Single ❑ Engaged ❑ Married ❑ Partnered ❑Separated ❑ Divorced ❑ Remarried ❑ Widow/
Widower

Employment
Current Employer: _______________________________ Position: _____________________________
Length of time in this position: _________ Stress level of this position: ❑ Low ❑ Medium ❑ High

Educational History

Highest Degree Completed: ❑Grade School ❑High School ❑College ❑ Graduate/Professional School

Are you currently a student? ❑No ❑Yes: Academic Institution: ____

Major: ________________________________

Current GPA: ___________

Military Service

Have you been/are you now in the military? ❑No ❑Yes, Dates:____

If yes, were you in combat? ❑No ❑Yes When/where? ____

Legal

Have you ever been convicted of a felony? ❑No ❑Yes What/when? ________________________________

Are you currently involved in any divorce or child custody proceedings? ❑No ❑Yes

If yes, please explain: ____

Current Concerns

Anxiety Issues

❑ Frequent worry
❑ Racing thoughts
❑ Panic attacks
❑ Fear away from home
❑ Phobias___________
❑ Obsessive thoughts
❑ Compulsive behavior
❑ Difficulties concentrating

Mood Issues

❑ Crying spells
❑ Sadness/depression
❑ Fatigue
❑ Lack of motivation
❑ Hopelessness
❑ Guilt/Shame
❑ Inability to enjoy things
❑ Mood swings
❑ Thoughts of death/ suicide

Self-Concept Issues

❑ Poor self-esteem
❑ Poor self-confidence
❑ Lack of self-worth
❑ Self-blame/self-criticism
❑ Body-image concerns
❑ Identity concerns

Anger Issues

❑ Physical aggression
❑ Irritability/anger
❑ Homicidal thoughts
❑ Property destruction

Interpersonal Issues

❑ Social isolation
❑ Social discomfort
❑ Relationship problems
❑ Peer conflict
❑ Parenting problems
❑ Family problems

Other Issues

❑ Eating problems
❑ Sleep problems
❑ Nightmares
❑ Flashbacks
❑ Cultural adjustment
❑ Spiritual/Religious Matters
❑ Work/school problems
❑ Death of a Loved One
❑ Sexual problems
❑ Self-harm behaviors
❑ Alcohol/drug use
❑ Gambling problems
❑ Problems with pornography
❑ Suspicion/paranoia
❑ Hearing voices
❑ Visual hallucinations
❑ Other:_____________________________
❑ Other:_____________________________

Current Symptoms

Please state the reason(s) and concern(s) for which you are seeking therapy:

What are your goals for therapy/What do you hope to accomplish by coming to therapy?

Mental Health History

In <u>the last 3 weeks</u>, have you had suicidal thoughts (i.e., thoughts of killing yourself)? ❑ No ❑ Yes

What is the frequency? ❑ N/A ❑ Rarely ❑ Sometimes ❑ Frequently ❑ Always

What is the intensity? ❑ N/A ❑ Brief & fleeting ❑ Focused deliberation ❑ Intense rumination

Have you seriously considered attempting suicide in the past? ❑ No ❑ Yes

Have you ever attempted to commit suicide? ❑ No ❑ Yes When? ______________________________

Briefly describe the circumstances:

Please check if you have experienced any of the following types of trauma or loss:

❑ Emotional abuse ❑ Teen pregnancy ❑ Homelessness ❑ Parent/Guardian substance abuse

❑ Physical abuse ❑ Multiple family moves ❑ Crime Victim ❑ Parent/Guardian illness

❑ Sexual abuse ❑ Relationship Violence ❑ Placed a child for adoption

Have you had previous counseling? ❑ No ❑ Yes

Dates of Service:__________ Duration of Therapy:_______________

Therapist:______________________________

Issues Addressed:

Do you have any previous mental health diagnoses (ie, Depression, Bipolar, PTSD)? ❑ No ❑ Yes:

Diagnosis:______________________________ Diagnosing therapist/physician:__________________
Date____________
Were you prescribed any medications for treatment? ❑ No ❑ Yes:
____

Diagnosis:______________________________ Diagnosing therapist/physician:__________________
Date____________
Were you prescribed any medications for treatment? ❑ No ❑ Yes:
____

Have you ever been hospitalized for a psychiatric reason? ❑ No ❑ Yes: when and for what reasons?

Health and Medical History

Please list any current health concerns:

Please list any history of significant accident, surgeries, illnesses or hospitalizations:

Please list any current medications, supplements or herbs:

Have you ever experienced any of the following medical conditions?
❑ Head injury ❑ Miscarriage ❑ Chronic pain ❑ Seizures ❑ Migraines ❑ Sexually-transmitted Disease
❑ Fainting spells ❑ Diabetes ❑ Abortion ❑ Asthma ❑ Frequent stomach upset

Do you regularly use alcohol? ❑No ❑Yes How often do you have **4 or more drinks** in a 24-hour period?
❑ Never ❑ Rarely ❑ Monthly ❑ Weekly ❑ Daily or Almost Daily
Do you consider your alcohol consumption a problem? ❑ No ❑ Yes

How often do you engage in recreational drug use? ❑ Never ❑ Rarely ❑ Monthly ❑ Weekly ❑ Daily

Family History

❑ Parents married/partnered & living together ❑ Mother remarried: Number of times ________
❑ Parents temporarily separated ❑ Father remarried: Number of times ________
❑ Parents divorced or permanently separated ❑ Parent deceased: ____________________________

Siblings & Ages:

Children & Ages:

Have any of your family members experienced any of the following (please indicate who):

- ❑ Attention/Hyperactivity Problems
- ❑ Anxiety
- ❑ Obsessive/Compulsive Behavior
- ❑ Depression
- ❑ Manic Depression (Bipolar)
- ❑ Schizophrenia
- ❑ Anger Management Problems
- ❑ Abusive Behavior
- ❑ Suicide Attempts
- ❑ Eating Disorder
- ❑ Sexual Abuse Survivor
- ❑ Alcohol Abuse
- ❑ Drug Abuse

Please describe how you usually cope with stress:

Please describe your strengths:

What are a few of your hobbies or interests?

If there is any additional information you would like to provide, please feel free to include it here:

Thank you for taking the time to complete this form!