RYAN A. LEWIS, M.A., LMHC
Psychotherapist

Client's Name:_____ Today's Date:_____

Partner's Name (if being seen as a couple): _____

Address, City, State, Zip: _____

Home phone:_____ Work phone: _____ Cell phone: _____

Private email address:_____ Student? If yes, where and major?_____

May we leave messages for you at home? Yes / No May we leave messages for you at work? Yes / No

Gender: M / F Age:_____ Birth Date:_____ Marital Status:_____

Others Living in Home (name, age, relationship to client):_____

_____

Highest Level of Education:_____ Occupation:_____

Client's Employer: (optional)_____

Emergency Contact: _____ Relationship to client_____ Phone:_____

Referred by / How did you hear about our services?_____

May we acknowledge our meeting to any referral source? _____

Have you received previous counseling and /or substance abuse treatment: yes _____ no _____

If Yes, Name & number of therapist/ Agency (optional)_____

Past Diagnoses? _____Months / Years in treatment _____

Name & number of primary care physician or health practitioner (optional)_____

Name & number of psychiatrist or psychiatric nurse practitioner (optional) _____

Any current medical or mental health conditions being treated? _____

Any current medications? yes ___ no___ [If yes, please list & include daily dose amounts]_____

_____

*Do we have your permission to discuss or receive treatment records and/or to receive diagnostic records from your past or current therapist, psychiatrist, and/or physician and/ or to disclose or share our clinical information with your past or current therapist, psychiatrist, and/or physician? yes _____ no_____ [A Release of Information-ROI form will be provided to you, if yes.]

**Signature [required] _____ Date [required]_____

FOR OFFICE USE ONLY: CLINICIAN'S CREDENTIALS: LH 60321405 DIAGNOSTIC CODE:

The Pioneer Building
600 First Ave., Suite 601
Seattle, WA 98104

Tel: 206.467.4080 | ryan@ryanlewiscounseling.com | www.ryanlewiscounseling.com

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Personal & Family Information

Ethnic identity & background _____Current relationship status_____

My birth parents currently: married/ live together ___ separated ___ divorced ____ never lived together ____ one or both deceased ___

Family of Origin [parents/ step parents, adoptive parents, siblings]

Name	**Relationship to you**	**Age or deceased**

Current Family & Household [partner/spouse, roommates, children]

Name	**Relationship to you**	**Age or deceased**

Check all that apply:

(History of)	**Family of Origin**	**Current Family & Household**
Counseling	_____	_____
Alcohol dependence	_____	_____
Drug dependence	_____	_____
Chronic physical Illness	_____	_____
Chronic mental illness	_____	_____
Depression	_____	_____
Anxiety	_____	_____
Eating Disorders	_____	_____
Domestic Violence	_____	_____
Sex Abuse and/ or Incest	_____	_____
Psychiatric hospitalization	_____	_____
Suicide Attempts	_____	_____

(check all that apply)

- I use alcohol: never____ daily____ Occasionally____ how many drinks on average per week_____
- I use drugs: never____ daily____ Occasionally____ how many times on average per week_____
- I use tobacco: never____ daily____ Occasionally____ how much on average per week_____
- I have experienced an unwanted sexual experience: recently_____ in the past_____
  If yes, please indicate: sexual assault_____ date rape____ rape____ incest_____

- My sleep is: _____ hours a night / Frequent waking? ____ (y/n) / Difficulty falling asleep? ___(y/n) Staying asleep? ___(y/n)

- I am dissatisfied with my personal appearance ___(y/n)
- I have felt like or tried to hurt myself in the past___(y/n) I'm currently hurting myself or thinking of hurting myself___(y/n)
- I have suffered a recent significant loss or death ___(y/n)
- I have suffered a recent relationship ending ___(y/n) other loss___(y/n) (Please list)_____
- I have experienced:
  - ___(y/n) medical complications at birth
  - ___(y/n) serious head injury (or knocked out)
  - ___(y/n) past learning disability or attention deficit/ hyperactivity disorder
  - ___(y/n) permanent disability (if checked yes, please describe) _____
  - ___(y/n) legal difficulties (if checked yes, please describe) _____

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Please state briefly your reasons for seeking services at this time.

What do you think may be getting in the way of you resolving your current problems or concerns?

What are a few of your current goals that you wish to achieve while participating in counseling, and how do you currently believe you can best achieve those goals?

How would you like things to be different after you have participated in counseling/ psychotherapy?

If you could wake up tomorrow with a different life or in a different situation, what would that life look like?

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Symptom Checklist

Please mark any of the following symptoms past or present and circle a number between 1 & 5.
(If the item does not apply to you, please leave it blank.)

Past / Present / Level of severity

- Past: Interfered with daily living in the past
- Present: Interferes with daily living or causes you mild to extreme distress
- 1: Little to no distress (symptoms occur infrequently, causes no interference with daily living)
- 3: Moderate distress (symptoms occur more often than not, moderate interference with daily living)
- 5: Severe distress (occurs daily, extreme interference with daily living)

Past___ Present___ 1 2 3 4 5	Depressed mood most of the day, nearly every day
Past___ Present___ 1 2 3 4 5	Loss of interest or pleasure
Past___ Present___ 1 2 3 4 5	Significant weight change
Past___ Present___ 1 2 3 4 5	Sleeping too much
Past___ Present___ 1 2 3 4 5	Loss of energy
Past___ Present___ 1 2 3 4 5	Fatigue
Past___ Present___ 1 2 3 4 5	Sleeping too little
Past___ Present___ 1 2 3 4 5	Feeling worthless or helpless
Past___ Present___ 1 2 3 4 5	Difficult concentrating or indecisiveness
Past___ Present___ 1 2 3 4 5	Feeling slowed down
Past___ Present___ 1 2 3 4 5	Recurrent thoughts of death
Past___ Present___ 1 2 3 4 5	Thoughts of suicide
Past___ Present___ 1 2 3 4 5	Feeling guilt
Past___ Present___ 1 2 3 4 5	Lack of motivation
Past___ Present___ 1 2 3 4 5	Feeling like a failure
Past___ Present___ 1 2 3 4 5	Feeling unattractive
Past___ Present___ 1 2 3 4 5	Feeling pessimistic about the future
Past___ Present___ 1 2 3 4 5	Self-blame or criticism
Past___ Present___ 1 2 3 4 5	Loneliness

Past___ Present___ 1 2 3 4 5	Easily distracted
Past___ Present___ 1 2 3 4 5	Feeling extra high or good
Past___ Present___ 1 2 3 4 5	Increased goal directed activity
Past___ Present___ 1 2 3 4 5	Grandiosity
Past___ Present___ 1 2 3 4 5	Little or no need for sleep
Past___ Present___ 1 2 3 4 5	Behavior that has caused problems
Past___ Present___ 1 2 3 4 5	Increased involvement in pleasurable activates with negative consequences
Past___ Present___ 1 2 3 4 5	Feeling agitated
Past___ Present___ 1 2 3 4 5	Racing thoughts
Past___ Present___ 1 2 3 4 5	Poor judgment
Past___ Present___ 1 2 3 4 5	Significant mood swings

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Past___ Present___	1 2 3 4 5	Acts of violent behavior/ uncontrollable anger or rage
Past___ Present___	1 2 3 4 5	Destroying property
Past___ Present___	1 2 3 4 5	Stealing items
Past___ Present___	1 2 3 4 5	Pulling out hair
Past___ Present___	1 2 3 4 5	Harming self
Past___ Present___	1 2 3 4 5	Preoccupation with the Internet
Past___ Present___	1 2 3 4 5	Preoccupation with shopping or spending
Past___ Present___	1 2 3 4 5	Preoccupation with sex
Past___ Present___	1 2 3 4 5	Preoccupation with gambling
Past___ Present___	1 2 3 4 5	Preoccupation with fire or starting fires
Past___ Present___	1 2 3 4 5	Thoughts of harming others
Past___ Present___	1 2 3 4 5	Hearing things that aren't there
Past___ Present___	1 2 3 4 5	Seeing things that aren't there
Past___ Present___	1 2 3 4 5	Feeling or sensing things that aren't there
Past___ Present___	1 2 3 4 5	Feeling like I am being punished
Past___ Present___	1 2 3 4 5	Feeling like others are out to get me
Past___ Present___	1 2 3 4 5	Difficulty getting along with others
Past___ Present___	1 2 3 4 5	Drug abuse or dependence
Past___ Present___	1 2 3 4 5	Alcohol abuse or dependence
Past___ Present___	1 2 3 4 5	Falling asleep from drinking or using drugs
Past___ Present___	1 2 3 4 5	Treatment for drugs or alcohol
Past___ Present___	1 2 3 4 5	Drug or alcohol related legal issues
Past___ Present___	1 2 3 4 5	Blackouts
Past___ Present___	1 2 3 4 5	Withdrawal symptoms from drugs or alcohol
Past___ Present___	1 2 3 4 5	High tolerance to drugs or alcohol
Past___ Present___	1 2 3 4 5	Fear of losing control
Past___ Present___	1 2 3 4 5	Fear the worst happening
Past___ Present___	1 2 3 4 5	Feeling dizzy or faint
Past___ Present___	1 2 3 4 5	Fear of dying
Past___ Present___	1 2 3 4 5	Sensations of shortness of breath
Past___ Present___	1 2 3 4 5	Trembling or shaking
Past___ Present___	1 2 3 4 5	Chest pain or discomfort
Past___ Present___	1 2 3 4 5	Feeling of choking
Past___ Present___	1 2 3 4 5	Panic Attacks

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Past___ Present___ 1 2 3 4 5	Having recurrent/persistent thought or worries
Past___ Present___ 1 2 3 4 5	Doing repetitive behaviors when nervous
Past___ Present___ 1 2 3 4 5	Feeling excess anxiety about being in certain situations
Past___ Present___ 1 2 3 4 5	Difficulty asserting yourself
Past___ Present___ 1 2 3 4 5	Irritability
Past___ Present___ 1 2 3 4 5	Restlessness
Past___ Present___ 1 2 3 4 5	Muscle tension
Past___ Present___ 1 2 3 4 5	Difficulty concentrating or mind going blank

Past___ Present___ 1 2 3 4 5	History of sexual abuse
Past___ Present___ 1 2 3 4 5	History of physical abuse
Past___ Present___ 1 2 3 4 5	History of emotional abuse
Past___ Present___ 1 2 3 4 5	Experience of traumatic events
Past___ Present___ 1 2 3 4 5	Recurrent troubling memories
Past___ Present___ 1 2 3 4 5	Recurrent distressing dreams
Past___ Present___ 1 2 3 4 5	Exaggerated response to being startled
Past___ Present___ 1 2 3 4 5	Outbursts of anger
Past___ Present___ 1 2 3 4 5	Feeling hypervigilant
Past___ Present___ 1 2 3 4 5	Fear of assault by strangers
Past___ Present___ 1 2 3 4 5	Flashbacks

Past___ Present___ 1 2 3 4 5	Lesbian, gay, bisexual, transgender, queer, intersex, asexual concerns (please circle appropriate concern)
Past___ Present___ 1 2 3 4 5	Acculturation concerns (multicultural issues)
Past___ Present___ 1 2 3 4 5	Religious or spiritual concerns and issues
Past___ Present___ 1 2 3 4 5	Problems in romantic relationships
Past___ Present___ 1 2 3 4 5	Problems with intimacy
Past___ Present___ 1 2 3 4 5	Lack of interest in sex
Past___ Present___ 1 2 3 4 5	Harassment related to my gender identity or sexual orientation
Past___ Present___ 1 2 3 4 5	Sexual concerns
Past___ Present___ 1 2 3 4 5	Pain during sex
Past___ Present___ 1 2 3 4 5	Difficulty having or sustaining an erection
Past___ Present___ 1 2 3 4 5	Other sexual concerns related to men (please describe) _____
Past___ Present___ 1 2 3 4 5	Other sexual concerns related to women (please describe) _____

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Past___ Present___ 1 2 3 4 5	Relationship problems
Past___ Present___ 1 2 3 4 5	Divorce
Past___ Present___ 1 2 3 4 5	Family or sibling problems
Past___ Present___ 1 2 3 4 5	Problems related to occupation or relationships at work
Past___ Present___ 1 2 3 4 5	Difficulty parenting
Past___ Present___ 1 2 3 4 5	Transitional concerns (difficulty adjusting)
Past___ Present___ 1 2 3 4 5	Environmental concerns
Past___ Present___ 1 2 3 4 5	Difficulty expressing emotions
Past___ Present___ 1 2 3 4 5	Difficulty setting boundaries
Past___ Present___ 1 2 3 4 5	Memory problems
Past___ Present___ 1 2 3 4 5	Headaches
Past___ Present___ 1 2 3 4 5	Physical pain (please describe) _____
Past___ Present___ 1 2 3 4 5	Poor appetite
Past___ Present___ 1 2 3 4 5	Overeating
Past___ Present___ 1 2 3 4 5	Limiting food intake, vomiting, and laxatives to control weight
Past___ Present___ 1 2 3 4 5	Binge eating
Past___ Present___ 1 2 3 4 5	Preoccupation with exercise
Past___ Present___ 1 2 3 4 5	Weight change of five pounds or more in last month
Past___ Present___ 1 2 3 4 5	Other concerns or issues: (Please list below)
Past___ Present___ 1 2 3 4 5	_____
Past___ Present___ 1 2 3 4 5	_____
Past___ Present___ 1 2 3 4 5	_____
Past___ Present___ 1 2 3 4 5	_____
Past___ Present___ 1 2 3 4 5	_____

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