Commonwealth Therapy

268 NEWBURY STREET – BOSTON, MA 02116
617.383.7220 | COMMONWEALTHTHERAPY.COM

Welcome to Commonwealth Therapy! We want to make the most of each appointment you have with us. One way of doing this is for you to write down some basic information in advance of your first appointment. Please fill out the following as completely and legibly as possible. This information is confidential. If you have concerns about the relevance of any information and wish to leave it out, please feel free to do so.

Name _____ Age _____ Date of Birth _____/_____/____

Address _____

_____

Phone _____ Email _____

Ethnicity_____ Where did you grow up? _____

Education _____ Occupation _____

Gender _____ Preferred Gender Pronoun _____ Relationship Status _____

What are your spiritual beliefs? _____

What are some of your personal strengths? _____

_____

Please describe your current living arrangement (Do you live with others?)

_____

Have you participated in therapy before? Y___N___ If yes, when? _____ Reason _____

Have you experienced any trauma? Y___N___

If yes, please circle: emotional/verbal/physical/sexual/medical/combat/other_____

Are you, currently seeing any other providers? Y___N___ Please list_____

Have you or a family member ever been hospitalized for mental or emotional illness? Y___N___

If yes, please explain—dates, where, reason: _____

Substance use/addiction history? Y___N___ If yes, please explain: _____

_____

Legal History (arrests, charges prison, DWI) _____

Primary Care Doctor _____Phone _____

May we send your doctor a short note, letting him/her know you've come to see us? Y____ N____

Please list all current medications – include prescription and over-the-counter:

_____

_____

How can we help? Please tell us in your own words what brings you here today. Feel free to describe this in as much or little detail as you wish.

_____

_____

_____

What are your two most important goals for therapy?

1. _____

2. _____

Are you having any suicidal thoughts, feelings, or actions? Y_____ N_____

If yes, explain _____

Have you ever had any suicidal thoughts, feelings, or actions? Y_____ N_____

If yes, explain _____

Are you having any homicidal or violent thoughts or feelings, or anger-control issues? Y_____ N_____

If yes, explain _____

Have you had any recent significant loss or harm (illness, separation, job loss, etc.)? Y_____ N_____

If yes, describe _____

Emergency Contact _____

Phone Number _____ Relationship to You _____

*I confirm that I have reported this information to the best of my knowledge. I authorize **Leah K Barison, LMHC** to contact the listed Emergency Contact in the case of emergency. **Leah K Barison, LMHC** may collaborate with my primary care doctor as needed.*

_____ _____

Client Signature Date