___ Conflicts over raising stepchildren
___ Conflicts over raising our own children
___ Other: ____

Medical History

Primary Physician:_______________________________ Date of last Physical:________
Clinic Name and Location:____
Please list any chronic or serious illnesses:______________________________________
____

List any previous suicide attempts:____
____

Current prescriptions/medications:____
____

Any previous medications used for emotional problems and whether or not they were helpful:____

Over the counter medicines used frequently:_____________________________________

Mental Health History

Please list previous therapy, hospitalizations, and/or evaluations:

When	Where	By Whom

Have any blood relatives experienced significant mental health problems? If so, explain.
____
____

___ No

Abuse History

Have you ever been abused?

Physically	___ Yes	___ No	___ Not sure
Emotionally	___ Yes	___ No	___ Not sure
Sexually	___ Yes		___ Not sure

Comments:____
____
Was abuse a problem in your family when growing up?___________
Is it currently a problem?_________

MINDFUL CONNECTIONS

Cultivating Awareness, Intention, and Intimacy

Bridget Manley Mayer, MS, LMFT
www.MindfulConnections.com
Bridget@mindfulconnections.com
Phone: 651-829-3950
366 Selby Avenue, Suite 200, St. Paul MN 55102

Have you or others ever thought your use of alcohol or drugs was a problem?
Alcohol ___ Yes ___ No
Smoking ___ Yes ___ No
Other drugs ___ Yes ___ No
Amount/type of alcohol per week: ____
Amount/type of other drug use per week: ___________________________________
Amount of tobacco use per day: ____
Amount/type of caffeine use per day: _____________________________________
History of chemical dependency treatments? _______________
If yes, when and where?
____
____
Do you attend AA or other similar groups? _________________________________
Are there any guns or weapons in the house?________________________________
Any legal charges (if so, please specify)? __________________________________
____

Sources of Stress

Please list the things/events/problems that are creating stress in your life at the present time (including significant losses and changes in your life):

1. _________________________________ 4. _______________________________
2. _________________________________ 5. _______________________________
3. _________________________________ 6. _______________________________

Current Functioning

Please list a number on a scale of one to ten with one indicating you are coping with things the worst you ever have in your life and ten indicating you are coping with things the best you ever have in your life: ______________
List the people in your life that are the most supportive and/or helpful to you at this time:
____
____
What do you consider to be your major strengths: ______________________________
____

Goals in Counseling

Please list the goals you hope to achieve in counseling. Please be as specific as you can.
1. ____
2. ____
3. ____
4. ____