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Welcome! I am looking forward to getting to know you. Please tell me a little bit about yourself.

Today's date: _____

Your name: _____
Last First Middle Initial

Date of Birth: _____ **Age:** _____

Home street address: _____

City: _____ **State:** _____ **Zip:** _____

Gender: _____ **Preferred Pronoun:** _____ **Sexual Orientation:** _____

Name of Employer: _____

Address of Employer: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Email:** _____

Calls will be discreet, but please indicate any restrictions (i.e. "do not leave voicemails"):

Referred by:

If referred by another clinician, would you like for us to communicate with one another?

Yes No

Person(s) to notify in case of any emergency:

I will only contact this person if I believe it is a life or death emergency. Please provide your initials to indicate that I may do so: _____

If applicable, please indicate the credit card you would like to leave on file with us below:

Name as it appears on card:

Card number:

3 or 4 digit code:

Expiration date:

Please briefly describe your presenting concern(s):

What are your goals for therapy?

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own?):

MEDICAL HISTORY:

Our physical and mental health are interrelated and connected. Please explain any significant medical problems, symptoms, or illnesses you have had:

Current Medications (if you need more room, please write on the back of this page):

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Previous medical hospitalizations (Approximate dates and reasons):

Previous psychiatric hospitalizations (Approximate dates and reasons):

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? If yes, please list approximate dates and reasons. Were you pleased with your care?

FAMILY:

Marital Status:

Single ____ Married ____ (# of Years ____ Months ____) Divorced ____ Separated ____

How would you describe your relationship with your significant other/spouse?

How would you describe your relationship with your mother?:

How would you describe your relationship with your father?:

Are your parents still married or did they separate/divorce? _____ If they separated or divorced, how old were you when your parents separated or divorced and how do you think this impacted you?

How would you describe your relationship with your siblings? (Please list how many siblings, ages, gender):

If you have kids, please list ages and any current or historical problems that have troubled you:

SOCIAL SUPPORT, SELF-CARE, & EDUCATION:

How would you describe your level of satisfaction with friends and social support currently?

How would you describe your relationship with your peers?

Please briefly describe any history of abuse, neglect and/or trauma:

How do you typically take care of your self or cope with stress/anxiety/depression?

What are your diet, weight, and exercise/activity patterns?

What are your hobbies, talents, and strengths?

Please describe your spiritual life or religious beliefs, if any:

Your name: _____

This section is to be completed individually by each participating family member. Circle any of the following terms that apply to you or a family member. Feel free to make notes, as needed.

Depressed mood	Significant ongoing physical pain	Alcohol usage
Lost interest or pleasure	Stomach problems	Drug usage
Lack of energy/fatigue	Headaches	Marital issues
Weight loss or gain	Bowel Problems	Divorce
Unable to concentrate	Balance problems	Separation
Excessive sleeping	Seizures	Affair/Infidelity
Difficulty sleeping	Learning/academic problems	Issues with ex-partner
Decreased need for sleep	Stuttering	Relationship issues
Pressure to keep talking	Attention difficulties	Parenting concerns
Racing thoughts	Frequent “on the go” behavior	Issues with friends
Excessive risk taking	Aggressive behavior towards others	Work/job issues
Recurring thoughts	Destructive behaviors	Financial issues
Repetitive behaviors	Frequent lying/deceitfulness	Issues at school
Traumatic/threatening events	Difficulty following rules	Shyness
Excessive anxiety/worry	Issues related to eating	Anger or rage
Hear or see things	Nightmares	Loneliness
Memory problems/loss	Issues with gambling/gaming	Insecurity
Suicidal thoughts	Pornography	Isolation
Physical abuse	Sexual abuse	Emotional abuse

If you have noticed any recent changes in the following areas, please circle those changes:

Vision	Hearing	Coordination	Balance	Strength
Speech	Memory	Energy	Sleeping	Menstruation
Elimination	Sleeping	Eating	Sexual Activity	

Please complete the following sentences:

1. The most important thing to me is
2. I worry about
3. What I do best is
4. I have sometimes felt guilty about
5. What makes me angry
6. My biggest mistakes were
7. My job
8. What makes me nervous is
9. My personality would be better if
10. I often felt that mother
11. My temper
12. My childhood
13. Prayer is
14. My biggest disappointment
15. To me, sex is
16. I would be better liked if
17. I often felt that father
18. God to me is
19. My children (child) (brothers and sisters)

20. Women are

21. What hurts me most is

22. My biggest problem in life is

23. Men are