Norma Fournier, LCSW

GENERAL INFORMATION

Today's Date: _________________ ID# ____________________ Referred by _______________________

____

Last Name First Name Middle Initial

____

Address

____

City State Zip

___________________ ______________________ ____________________________

Home Phone Work Phone Cell Phone

Emergency Contact Person (name & phone): ____

__________ _________________________ __________________ ________________

Date of Birth Place of Birth Race/Ethnicity Sexual Orientation

______________________ ______________________________ _________________________________

Occupation Employer Highest Educational Degree

Relationship Status: ___ Single ___ Married/Partnered ___Separated ___ Divorced ___Widowed

Current Income:

__ Less than $15,000 __ $15,000-24,999 __ $25,000-34,999 __ $35,000-44,999 __ Over $45,000

Insurance Provider (s) ____

FAMILY HISTORY

List immediate family (spouse/partner, children, parents, siblings)

First Name	Age	Relationship to you	Occupation
____________________	___	________________	______________________________
____________________	___	________________	______________________________
____________________	___	________________	______________________________
____________________	___	________________	______________________________
____________________	___	________________	______________________________
____________________	___	________________	______________________________
____________________	___	________________	______________________________
____________________	___	________________	______________________________

HEALTH

Do you have any health conditions that concern you? ___ Yes ___ No

If yes, please describe: ____

____

Are you presently taking any medication? ___ Yes ___ No

If yes, please describe: ____

____

Have you received psychological services in the past? ___ Yes ___ No

If so, when and for how long: ____

Any other information you feel it would be important for me to know about you:

____

____

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____

Self-Report Checklist

Please rate any issues below that are areas of concern for you by circling the appropriate number.

	No problem	Mild	Moderate	Severe		No problem	Mild	Moderate	Severe
1. Depression	0	1	2	3	**16. Suicidal feelings or behavior**	0	1	2	3
2. Anxiety, fears, worries	0	1	2	3	**17. Discrimination, oppression**	0	1	2	3
3. Irritable, angry, hostile feelings	0	1	2	3	**18. Assertiveness**	0	1	2	3
4. Self-esteem, Self-confidence	0	1	2	3	**19. Religious, spiritual issues**	0	1	2	3
5. Relationship with family	0	1	2	3	**20. Dealing with physical disability**	0	1	2	3
6. Relationship with friends	0	1	2	3	**21. Chronic health problems**	0	1	2	3
7. Relationship with romantic partner	0	1	2	3	**22. Physical stress**	0	1	2	3
8. Loss or death of significant person	0	1	2	3	**23. Eating problems**	0	1	2	3
9. Identity issues	0	1	2	3	**24. Sleep problems**	0	1	2	3
10. Coming out as gay, lesbian, or bisexual	0	1	2	3	**25. Alcohol and/or other drugs**	0	1	2	3
11. Sexual decisions, issues	0	1	2	3	**26. Career decisions**	0	1	2	3
12. Sexual harassment	0	1	2	3	**27. Employment issues**	0	1	2	3
13. Childhood physical abuse, emotional abuse, neglect	0	1	2	3	**28. Financial issues**	0	1	2	3
14. Childhood sexual abuse, molestation	0	1	2	3	**29. Legal issues**	0	1	2	3
15. Rape or sexual assault	0	1	2	3	**30. Other** ________________ **(please specify)**	0	1	2	3