Rooted Counseling, PLLC
rootedcounseling.net
403 W Cherry Ln • Meridian, ID 83642
one: (208) 887-1911 ext 105 • Fax: (208) 895-8049
Email: luis.cortez0712@gmail.com

Welcome! I am excited to learn more about you so we can begin the healing and helping process. You are the expert on your life and I am honored to be a part of your journey. My office is a judgement free zone and I will try my best to show you understanding, compassion, warmth and respect. We will review this form together on the first meeting, where you can ask questions and we can clarify goals for treatment.

Today's Date:

Name:

Address:

Date of Birth:

Age:

Phone number:

Ok to leave Voice Mails?

Email:

Primary Language:

Interpreter needed: Yes No

Emergency Contact (name and phone number):

What brings you into counseling today:

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How would you rate your current mental health? Excellent Good Average Poor Failing

SYMPTOMS:

1.

2.

3.

4.

5.

How do these symptoms affect you in your day to day life?

Mental Health History

Have you ever been in counseling before? YES NO
If yes, what did you find helpful/effective vs unhelpful/ineffective?

Are you currently receiving any mental health services? YES NO
If yes, please list name of practitioner and type of services you are receiving:

What, if any, prior diagnosis have you received?

Have you ever been hospitalized for mental health concerns? YES NO
If yes, list date(s) and length of stay:

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Risk Assessment and Self Harm

Have you ever or are you currently engaging in self harm behaviors?

If yes, what type of self harm and how often?

Have you experienced any of the following:

Extreme depressed mood	YES	NO	
Extreme mood swings	YES	NO	
Rapid speech	YES	NO	
Extreme anxiety	YES	NO	
Panic attacks	YES	NO	
Phobias	YES	NO	
Hallucinations	YES	NO	
Unexplained losses of time	YES	NO	
Unexplained memory lapses	YES	NO	
Eating disorder	YES	NO	
Repetitive behaviors	YES	NO	(frequent checking, handwashing, etc)
Homicidal thoughts	YES	NO	
Suicidal thoughts	YES	NO	
Suicide attempts	YES	NO	

Please explain any items which you circled YES:

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Medical History

How would you currently rate your physical health? Excellent Good Average Poor Failing

What, if any, physical symptoms or medical diagnosis do you have?

Are you currently under the care of a medical doctor or other medical health professional?

If yes, name of your Primary Care Physician:

If yes, phone for your Primary Care Physician:

Are you taking any prescription medications? YES NO
Please list:

Are you taking any over the counter medications, vitamins, or herbal supplements? YES NO
Please list:

Basic Living Questions
Do you currently engage in movement/exercise? YES NO

How often and what types of movement/exercise?

How are your sleep habits (routine, amount, rested)?

Are you having any difficulty with appetite or eating habits? YES or NO
Please explain if yes:

Have you experienced significant weight change in the last 2 months? YES or NO
Please explain if yes:

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Vocational History
Are you currently employed? YES NO
If yes, what type of work are you involved in?

Other important facts about your current or past work/school history:

Trauma History
Please indicate if you or an immediate family member experienced any of the following (if a family member please note how related):

Emotional abuse:

Physical abuse:

Sexual abuse:

Domestic violence:

Neglect:

Substance abuse:

Serious illness:

Accident or injury:

Legal problems:

Frequent/multiple moves:

Homelessness:

Financial Problems:

Other unspecified:

Please explain: