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Psychotherapist
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303-562-6328

Date _____

Contact Information

Name _____

Address: _____

Phone: Home: _____ Work: _____ Cell _____

Is it okay to leave a message at any of these numbers? If so, circle which one.

Email: _____

Personal Information

Occupation

Education

Gender Identification

Ethnic/Cultural Identification

Current Living Situation

Relationship Status

Do you have children? If so, names and ages?

Briefly describe the history of your relationships

Background Information

Why are you seeking therapy at this time?

Briefly describe any major losses or traumas in your life.

Are you currently being seen by a psychiatrist? ___Yes ___No

Psychiatrist: _____ Phone: _____

Please check any of the following that apply to you:

- Nightmares Difficulty with anger Can't pay attention Unhappy with work
- Tense Unable to make friends Panicky Feel hopeless
- Feel guilty Financial problems Lonely Hears voices
- Can't concentrate Unable to make friends Difficult homelife Unable to find a job
- Suicidal thoughts Can't make decisions Problems with sex Unable to keep a job
- Homicidal thoughts Racing thoughts Anxious Poor memory
- Other _____

Psychotherapy History

Please list any previous mental health services including hospitalizations:

Therapist/Doctor	Dates	Reason for Treatment
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Have you ever attempted suicide? _____ If so, when, how, and what happened?

Have you ever engaged in self-harm? _____ If so, when? _____
Now? _____

Describe the self-harm
behaviors _____

Does anyone in your family have any history of mental illness, suicide, substance abuse,
trauma, or abuse? If yes, please describe
briefly: _____

Medical History

Please list any significant medical conditions (past/present):

Prescribed Medications (past/present):

Alcohol/Drug History

Current use of alcohol/recreational drugs: _____

Previous use of alcohol/recreational drugs: _____

Support System

Who are the supportive people in your life?

___ Parents ___ Children ___ Partner

___ Religious/Spiritual community ___ Professional caregiver ___ Friends

___ Relative(s) ___ Sibling(s) ___ Pet(s)

___ Other