

Ψ SHAWN CHRISTINE HORN, PSYD, PS Ψ

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Preferred Name: _____

Gender: _____

Sexual Orientation: _____

Ethnicity/Race: _____

Religious Affiliation/Spirituality: _____

Relationship Status: _____

Who referred you to our office today? _____

Please describe the specific problems that prompted you to seek help at this time:

Have you attended counseling for mental health concerns? _____

If yes, when? _____

Where? _____

Who did you see? _____

Have you taken a prescribed medication for mental health concerns? _____

If yes, when? _____

Medications: _____

Have you ever been hospitalized for mental health concerns? _____

If yes, when? _____

Have you ever received treatment for alcohol or other drug use? _____

If yes, when? _____

Do you have a family member with a history of mental health concerns? _____

If yes, who? [54918]

Do you have a family member with a history of alcohol or other drug use concerns?

If yes, who?

Have you experienced any abuse and/or assault? _____

If yes, types of abuse/assault experienced:

Are you having current suicidal thoughts? _____

Have you seriously considered attempting suicide? _____

If yes, when? _____

Have you made a suicide attempt? _____

If yes, when? _____

How? _____

Have you purposely hurt yourself without the intention of committing suicide? _____

If yes, when? _____

How? _____

Have you seriously considered physically harming another person? _____

If yes, when? _____

Have you had eating/body image concerns? _____

If yes, when? _____

Have you had a traumatic event in your life? _____

If yes, when? _____

Have you recently experienced any type of loss? _____

How often do you drink alcohol? _____

Type(s) of alcohol used: _____

Average amount consumed: _____

How often do you use other drugs? _____

Type(s) of drug(s) used: _____

Average amount used: _____

Have you ever recreationally used any substances (even one time)? _____

Do you have any physical health concerns? _____

Is there any other information you would like us to know? _____

Impact of Current Concerns:

Please indicate the degree to which each of the below items is currently affecting you where 0 = no concern, 1 = little concern, 2 = moderate concern, and 3 = significant concern.

1.	Persistent feelings of sadness, helplessness, or despair	
2.	Suicidal thoughts or plans to run away	
3.	Insomnia or inability to sleep	
4.	Appetite disturbance (unable to eat, overeating, etc.)	
5.	Tension or nervousness	
6.	Difficulty trusting people	
7.	Class absences	
8.	Loneliness or feeling isolated	
9.	Thinking of dropping out of school	
10.	Indecision about major / career choice	
11.	Too easily influenced by others	
12.	My sexual identity and/or orientation	
13.	Financial problems	
14.	Don't like or feel comfortable in my body	
15.	Religious or spiritual beliefs	
16.	Sexual problems	
17.	Student conduct concerns	
18.	Legal problems	
19.	Problems with alcohol	
20.	Problems with marijuana or other drugs	
21.	Stress or feeling overwhelmed	
22.	Relationship problems	

I hereby consent and agree to assessment, counseling, consultation, and treatment by Shawn Horn PsyD, PS. I understand that this consent will remain in effect until the end of our treatment, and that I have the right to later revoke my consent.

Client signature as consent to treat: _____

The above information was completed by the client and will not be altered by the provider.