# Samantha Endicott Therapy

**Samantha L. Endicott, M.Ed., LPCC, & Wellness Coach**
**101 Wind Haven Dr., Ste #202**
**Nicholasville, KY 40356**

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## New Client Information
## (Please Print Clearly)

**Today's Date:** _____

**Name:** _____

**Parent/Legal Guardian (if under 18):** _____

**DOB:** _____ **Age:** _____ **Gender:** _____

**Address:** _____

**Preferred Phone #:** _____ **May I Leave a Message?** Y N

**Email:** _____
**Please note: Email correspondence is not considered to be a confidential medium of communication.*

**Marital Status (Please check one):**

| | | |
|---|---|---|
| Never Married | Separated | Domestic Partnership |
| Divorced | Married | Widowed |

**Are you currently employed? Yes No** **Employer:** _____

**Referred By (if any):** _____

**Emergency Contact:** _____ **Phone:**_____

**Relationship to Client:** _____

**Presenting Problem: In your own words, describe why you are here today:**

_____

_____

_____

_____ _____
**Client Signature** **Date**

_____ _____
**Parent/Legal Guardian Signature (if applicable)** **Date**

## History

**Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?**

**No Yes, previous therapist/practitioner: _____**

**Are you currently taking any prescription medication? Yes No**

**If yes, please list all medications:**

_____

_____

**Have you ever been prescribed psychiatric medication? Yes No**

**If yes, please list all medications and provide dates:**

_____

_____

## General and Mental Health Information

**How would you rate your current physical health? (Please circle one)**

**Poor Unsatisfactory Satisfactory Good Very good**

**Please list any specific health problems you are currently experiencing:**

_____

_____

**When were you last seen by your Primary Care Physician/Pediatrician?**

_____

**Who is your Primary Care Physician (PCP)/Pediatrician?_____**

**PCP/Pediatrician Address: _____**

**PCP/Pediatrician Phone #: _____**

# Stress Symptom Checklist

Check each item that describes a symptom you have experienced to any significant degree during the last month:

## PHYSICAL SYMPTOMS

Headaches
Backaches
Tight muscles
Neck and shoulder pain
Jaw tension
Muscle cramps, spasms
Nervous stomach
Nausea
Insomnia (sleeping poorly)
Fatigue, lack of energy
Cold hands/feet
Tightness or pressure in head
High blood pressure
Diarrhea
Skin condition
Allergies
Teeth grinding
Digestive upsets (cramping, bloating)
Stomach pain, ulcer
Constipation
Hypoglycemia
Appetite change
Colds
Profuse perspiration
Heart beats rapidly or pounds, even at rest
Use of alcohol, cigarettes, or recreational drugs

## PSYCHOLOGICAL SYMPTOMS

Anxiety
Depression
Confusion or spaciness
Irrational fears
Compulsive behaviors
Forgetfulness
Feeling overloaded/overwhelmed
Mood Swing
Loneliness
Problems with relationships
Dissatisfied/unhappy at work
Difficulty concentrating
Frequent irritability
Restlessness
Frequent boredom
Frequent worrying or obsessing
Frequent guilt
Temper flare-ups
Crying spells
Nightmares
Apathy
Sexual problems
Overeating
Stress level
Hyperactivity (can’t slow down)

## Family Mental Health History

In the section below, please indicate if there is a family history of any of the following mental health issues. If yes, please list the name of the family member(s) and his/her relationship to you in the space provided (i.e. mother, brother, grandfather, etc.)

| | | |
|---|---|---|
| Alcohol/Substance Abuse | Yes/No | _____ |
| Anxiety | Yes/No | _____ |
| Depression | Yes/No | _____ |
| Domestic Violence | Yes/No | _____ |
| Eating Disorders | Yes/No | _____ |
| Obesity | Yes/No | _____ |
| Obsessive Compulsive Disorder | Yes/No | _____ |
| Schizophrenia | Yes/No | _____ |
| Suicide Attempts | Yes/No | _____ |
| Other | Yes/No | _____ |