St Louis DBT, LLC
1034 S. Brentwood Blvd, Richmond Heights, MO 63117
314-932-7415 | info@stldbt.com | www.stldbt.com

Mindful Way through Depression Information Form

Name _____ Date of Birth_____

Mailing Address _____

Phone _____ May we leave a message? Y / N May we text? Y / N

Email _____ Alternative Phone _____

How do you prefer we contact you? (Circle one) Phone Text Email No Preference

Emergency Contact _____ Phone_____

Do you have a history of any of the following? (Check ALL that apply)

- ☐ Depression
- ☐ Anxiety
- ☐ Eating disorder
- ☐ Alcohol/substance abuse
- ☐ Bipolar disorder
- ☐ OCD
- ☐ Schizophrenia
- ☐ PTSD
- ☐ ADHD
- ☐ Borderline Personality Disorder
- ☐ Other Personality Disorder
- ☐ Other _____

If you checked depression?

Current Situation of Depression

Are you currently depressed? Yes / No

If yes, how would you describe your depression? (Circle one) Severe Moderate Mild

Are you currently taking medication for depression? Yes / No

Are you currently in therapy for depression? Yes / No

Have you thought about suicide in the last two weeks? Yes / No

If yes, do you have a plan to commit suicide? Yes / No

Have you cut or burned yourself in the past two weeks? Yes / No

Past History of Depression

When were you last depressed? _____

Have you ever been prescribed medications for depression? Yes / No

Have you ever had therapy for depression? Yes / No

Roughly at what age did you first notice you were depressed? _____

Roughly how many episodes have you had in the last 10 years? _____

Have you ever attempted suicide? Yes / No If yes, when was most recent? _____

Current Situation of Anxiety

Are you currently anxious? Yes / No

If yes, how would you describe your anxiety? (Circle one) Severe Moderate Mild

Are you currently taking medication for anxiety? Yes / No

Are you currently in therapy for anxiety? Yes / No

Have you had a panic attack within the last two weeks? Yes / No

Past History of Anxiety

When were you last anxious? _____

Have you ever been prescribed medications for anxiety? Yes / No

Have you ever had therapy for anxiety? Yes / No

Roughly at what age did you first notice anxiety? _____

Roughly how often have you felt anxiety in the last 10 years? (Circle one)

None Sometimes Most of time All of time

Do you have a history of panic attacks? _____

Are you currently in individual therapy? Y / N

If yes, With whom: _____When: _____

Where: _____ Length of Treatment:_____

Problems Treated: _____

_____

_____

What symptoms bother you most NOW, if any?

- ☐ Sadness
- ☐ Uncertainty about the future
- ☐ Hopelessness
- ☐ Lack of energy
- ☐ Sleep too much/too little
- ☐ Weight gain/loss
- ☐ Worry about other's judgment
- ☐ Self-judgment
- ☐ Isolation
- ☐ Excessive guilt
- ☐ Worry about getting out of control
- ☐ Fear your depression will come back
- ☐ Negative thoughts
- ☐ Panic attacks
- ☐ Can't stop your thoughts
- ☐ Out of body experiences
- ☐ Excessive worry
- ☐ Fear of dying
- ☐ Suicidal thoughts or want to die
- ☐ Irritability
- ☐ Fear about not being perfect
- ☐ Flashbacks
- ☐ Chronic pain
- ☐ Other _____
- ☐ No symptoms currently

How do you think you are managing your symptoms currently?

1 2 3 4 5 6 7 8 9 10

Extremely well Not well at all

What do you think might contribute to your depression and anxiety? (Check all that apply and * the top three)

- ☐ Major events (e.g., job loss, death, divorce, accident)
- ☐ Seasonal changes
- ☐ Postpartum
- ☐ Physical health problems or disability
- ☐ Stress at work, home, school
- ☐ Stage of life
- ☐ Problems with sleep
- ☐ Depression just comes out of nowhere
- ☐ Relationship problems
- ☐ Money problems
- ☐ Negative thoughts
- ☐ Can't stop my thoughts
- ☐ Worry thoughts
- ☐ Other _____

What do you do to reduce symptoms of depression and anxiety? (Check all that apply)

- ☐ Exercise/sports
- ☐ Meditation
- ☐ Spend time with friends & family
- ☐ Therapy
- ☐ Medication
- ☐ Keep busy with interests/hobbies/recreation
- ☐ Work
- ☐ Positive thinking
- ☐ Light therapy
- ☐ Massage
- ☐ Yoga
- ☐ Spend time outdoors
- ☐ Use good sleep habits
- ☐ Eat healthy
- ☐ Other _____

Who would you talk with if you started to become depressed or anxious?

_____

_____

_____

Do you have experience with Cognitive Behavioral Therapy (CBT)? Yes / No

If yes, please describe: _____

_____

_____

_____

Do you have experience with meditation? Yes / No

If yes, please describe: _____

_____

_____

_____

What concerns, if any, do you have about participating in the class? _____

_____

_____

_____

Is there anything else we should know about you? _____

_____

_____

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_____

Signature _____ Date _____