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Patient Information:

Today's Date: _____

Patient Name: (First) _____ (Middle Initial) _____ (Last) _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ ***Permission to contact*** () Yes () No

Address: _____ City: _____

State: _____ Zip: _____ D.O.B.: _____ Age: _____ () Male () Female

Work Status: () FT Employed () PT Employed () FT Student () PT Student () Homemaker () Retired () Other

Employer's Name / Address: _____

Occupation/Job Title: _____ Work/Shift Hours: _____

Referred By: _____ Phone: _____

Address: _____

May I contact them to thank them for your referral? : () Yes () No

Emergency Contact:

In case of an emergency you have my permission to contact: _____

Address/Phone #: _____ *Your Initials:* _____

Health History:

Please list any current or recurring health problems: _____

Are you presently taking any medications? () Yes () No If yes, please list name, use, and dosage: _____

Have you had previous mental health treatment? () Yes () No Are you in current mental health treatment? () Yes () No

Have you had any psychiatric hospitalizations? () Yes () No If yes, please indicate with whom, dates you attended and /or hospitals: _____

Reasons for seeking counseling:

Please state briefly why you are seeking assistance now and what you would like to achieve: _____

Symptom Checklist

These symptoms may or may not be related to the problem(s) that bring you in to see us. However, they may help in planning your treatment. Please check the "C" for current symptoms or "P" past symptoms.

	C	P			C	P	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	trouble going to sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	allergy problem? specify _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	restless sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	waking up very early and being unable to go back to sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	seizures
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	menstrual irregularity or distress
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feeling guilty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	asthma attack
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	depressive feelings that are regularly worse in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	irritable bowels, constipation, diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	thoughts about suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	tics
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	have made suicide attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	heart disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	fatigue or loss of energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	eating disturbance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	poor concentration and memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	frequent flu or colds
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	decreased sex drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sinus problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	significant feelings of restlessness, agitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	grinding teeth, jaw tension/pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	loss of pleasure in usual activities; have lost your zest for life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	endocrine dysfunction, e.g. thyroid problems, hypoglycemia, diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	appetite loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	kidney problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feeling worthless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	head injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	weight loss/how much in how long? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	smoking
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	weight gain/how much in how long? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	over eating
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feelings of sadness, depression, hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	over spending
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	withdrawing from others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	gambling problem
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	palpitations, rapid heart beat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	use alcohol/drugs. If you do, how frequently _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	light headedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	how much _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sweating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	other health issue _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	trembling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sense of dread	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feeling lonely even when with others
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	muscle tension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feeling shy or uneasy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chest pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	wanting to be alone often
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feeling bored with others
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	arguing with others
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feeling critical of others
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feeling people dislike you
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cold, clammy hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feel that people are out to harm you
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	afraid of losing control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	other relationship problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	avoiding certain situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feel others do not understand you
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	difficulty communicating what you really think or feel
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	tense or anxious all day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feel others do not meeting your needs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	very anxious in social situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feel others are inferior to you
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	recurring troubling thoughts, images, impulses you can't get out of your mind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feeling inadequate, less than others
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	repetitive behaviors such as excessive hand washing, etc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	have phobias (fears); of what? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	decreased need for sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	increased sex drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feel that you can read people's minds
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	greatly increased energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	have homicidal thoughts
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	described by friends as hyper or excitable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	see visions/hear voices
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	have special powers
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feel that people can read your mind
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	lower back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feel that people control your actions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	nausea, upset stomach, indigestion, ulcers, vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anything else you would like me to know? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hot or cold spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	numbness or tingling in parts of your body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Childhood and Family History

Current Living Situation:

Spouse/Significant Other's Name: _____

Age: _____ Spouse/Significant Other's Occupation: _____

Children's Names and Ages:

Name	Age	Name	Age	Name	Age

Who currently lives in your household? _____

Background Information:

What is your ethnic, cultural and religious background? _____

List your brothers and sisters from oldest to youngest and their ages. Indicate (B) biological, (S) step or (H) half sibling please:

Name	Age	Name	Age	Name	Age

Did your parents live together throughout your childhood? Yes No If not, what happened and how old were you? _____

Number of times moved and at what age: _____ Grew up in _____

Special problems in the family: Disabled child Parents fought Death in the family Hospitalizations Alcohol/drugs
 Serious medical illness Parent unemployment Parent changed jobs a lot Legal problems Other _____

What were you like as a child? Had problems learning in school Got into trouble in school Had problems with the law
Other (please explain): _____

Did you have any of these problems with your family? Physically abused Sexually abused Fought with parents
 Felt like you did not belong Had too much responsibility Isolated yourself from the family Emotionally abused
 Other _____

Take these few lines to describe your childhood and your relationship with your parents:
