Client Name:_____

PRESENTING PROBLEMS

CHECK ANY OF THE SYMPTOMS THAT YOU ARE HAVING

Depression__
Extreme sadness__
Trouble concentrating__
Memory problems__
Change in eating habits__
Feelings of extreme
Happiness__
Trouble performing
Your job__
Lack of enjoyment of
Usual activities__
Self esteem problems__
Perfectionism__
Obsessions or compulsions__
Feeling fearful__
Physical complaints of pain__
Problems with anger__
Problems getting along with
Family or friends__
Thoughts about hurting
Yourself or others__
Feeling hopeless__
Feeling tearful__
Change in sleeping habits__
Lack of energy__
Weight change__
Change in sexual interest or function__
Feeling guilty__
Feeling nervous__
Sudden feelings of panic__
Muscle tension__
Acting violently__
Thought about killing
Yourself or others__
Feeling stressed__
Easily irritated__

PLEASE CHECK ANY FAMILY HISTORY OF THE FOLLOWING

Depression__
Anxiety disorders__
Attention Deficit Disorder__
Mental illness__
Bipolar disorder__
Alcoholism or drug abuse__
Suicide__

Please continue on next page

Client Name:_____

HAVE YOU EVER BEEN IN COUNSELING BEFORE? YES___ NO __
If yes, please continue:

Dates of counseling	Name of counselor	Reason for counseling and outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL INFORMATION

Name of your Primary care doctor: _____ Telephone_____
Have you seen your doctor within the last year? Yes___ No___
Why have you seen your doctor?

Are you taking any kind of medical prescription or over the counter (herbal medicines, vitamins, etc?)
Yes___ No___
If yes, please list the medicines you are taking:

Do you have allergies to any medicines? Yes___ No___
If yes, please describe the allergy problems you have:

How would you rate your current physical health? Please circle:

Poor Unsatisfactory Satisfactory Good Very Good

How many times per week do you currently exercise?_____
Type of exercise _____

Please list any difficulties you experience with your appetite or any eating problems:
_____

Do you or have you used tobacco in any form? Current___ Past___ None___
If yes, what form?_____ Amount per day?___

Do you or have you used alcohol? Current___ Past___ None____
If current, how many drinks per day____ or week____ or month____?
Have you ever been referred for treatment for alcohol use? Yes___ No___

Client Name _____

Do you or have you used caffeine in any form (coffee, tea, cola, etc)? If so, amount per day_____

Do you or have you used recreational drugs? Current____ Past___ None____
If so, please list drugs used _____
Amount per day____ Week____ Month____?
Have you ever been referred for treatment for drug use? Yes___ No___

Are you currently involved in a romantic relationship? Yes___ No___
If yes, how long?____
On a scale of 1-10, please rate your satisfaction with your relationship. _____

Please indicate any significant life changes or stressors you have recently experienced.

_____
_____
_____
_____

What are your strengths?

_____
_____
_____
_____

What are your weaknesses?

_____
_____
_____
_____
_____

What are your goals for treatment?

_____
_____
_____
_____

Client Name:_____

Are you currently in treatment with another mental health provider? Yes___ No___

If so, may I have permission to contact them? Yes___ No ___

Name of provider: _____

Telephone number:_____

Please indicate anything about your spiritual life that you believe would impact your treatment:

Please indicate anything about your heritage or culture that you believe would impact your treatment:

What is your highest level of education? _____

Please feel free to write anything else you want to be known about you that you think is important as you access treatment.

Thank you for taking the time to answer these questions.