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Please complete the following question to allow me to better understand what brought you here for counseling. The additional information requested will be used to complete your comprehensive assessment.

Name_____Date_____

Employer_____

Primary Care Physician_____Phone_____

Are you currently seeing a psychiatrist? Yes No

If yes,

Name_____Phone_____

The following is a symptom checklist. Please circle each item based on severity, where 1=not a problem to 5=a severe problem.

Changes in sleep pattern	1	2	3	4	5
Changes in eating pattern	1	2	3	4	5
Sexual problems	1	2	3	4	5
Performance at work	1	2	3	4	5
Satisfaction in primary relationships	1	2	3	4	5
Coping with recent losses	1	2	3	4	5
Difficulty with daily routine	1	2	3	4	5
Letting others take advantage of you	1	2	3	4	5
Hyperactivity	1	2	3	4	5
Repeating certain acts	1	2	3	4	5
Using alcohol to cope	1	2	3	4	5
Using drugs to cope	1	2	3	4	5
Worrying about your health	1	2	3	4	5
Depression or sadness	1	2	3	4	5
Euphoria or feeling high	1	2	3	4	5
Confusion	1	2	3	4	5
Feeling angry or hostile	1	2	3	4	5
Anxiety or nervousness	1	2	3	4	5
Lack of energy	1	2	3	4	5
Sudden changes in mood	1	2	3	4	5
Difficulty concentrating	1	2	3	4	5
Feeling guilty	1	2	3	4	5
Thoughts of hurting others	1	2	3	4	5
Thoughts of hurting self	1	2	3	4	5
Feeling worthless	1	2	3	4	5
Withdrawal from others	1	2	3	4	5
Memory problems	1	2	3	4	5
Functioning at home	1	2	3	4	5

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Current Medical Problems

_____
_____
_____

Current Medications and Dosage

_____
_____
_____

Adverse Drug Reactions

_____
_____
_____

Allergies

_____
_____
_____

Prior Treatment: Year_____Duration_____
Name of Therapist or
Psychiatrist_____
What are your goals for therapy?

_____
_____
_____

Below is a substance use chart followed by questions about your current physical health. Please complete each item carefully.

	Past Amount per Day	Present Amount per Day
Cigarettes		
Alcohol		
Ilegal Drugs (marijuana, cocaine, etc)		
Prescription Drugs		
OTC Drug use (Tylenol, Benedryl)		