Patient Name _____ **Appointment Date** _____

Describe the problems that concern you:

Presenting Problems and Concerns (History of Present Illness)

Please check all of the behaviors and symptoms that you consider problematic:

[ ] Distractibility	[ ] Change in appetite	[ ] Suspicion/paranoia	[ ] Hyperactivity	[ ] Lack of motivation
[ ] Racing thoughts	[ ] Impulsivity	[ ] Withdrawal from people	[ ] Excessive energy	[ ] Boredom
[ ] Anxiety/worry	[ ] Wide mood swings	[ ] Poor memory/confusion	[ ] Panic attacks	[ ] Sleep problems
[ ] Seasonal mood changes	[ ] Fear away from home	[ ] Nightmares	[ ] Sadness/depression	[ ] Social discomfort
[ ] Eating problems	[ ] Loss of pleasure/interest	[ ] Obsessive thoughts	[ ] Gambling problems	[ ] Hopelessness
[ ] Compulsive behavior	[ ] Computer addiction	[ ] Thoughts of death	[ ] Problems with pornography	[ ] Aggression/fights
[ ] Self-harm behaviors	[ ] Frequent arguments	[ ] Parenting problems	[ ] Crying spells	[ ] Irritability/anger
[ ] Sexual problems	[ ] Loneliness	[ ] Homicidal thoughts	[ ] Relationship problems	[ ] Low self worth
[ ] Flashbacks	[ ] Work/school problems	[ ] Guilt/shame	[ ] Hearing voices	[ ] Alcohol/drug use
[ ] Fatigue	[ ] Visual hallucinations	[ ] Auditory hallucinations	[ ] Suicidal thoughts	

Are your problems affecting any of the following?

[ ] Handling everyday tasks	[ ] Self esteem	[ ] Relationships	[ ] Hygiene	[ ] Work/school
[ ] Housing	[ ] Legal matters	[ ] Finances	[ ] Recreational activities	[ ] Sexual activity
[ ] Health				

Have you ever had suicidal thoughts (with or without a plan)? [ ] Yes [ ] No Did you have a plan? [ ] Yes [ ] No

If yes to any of the above, please describe: _____

Have you ever had homicidal thoughts? [ ] Yes [ ] No Did you have a plan? [ ] Yes [ ] No

If yes to any of the above, please describe: _____

Have you ever had thoughts, made statements, or attempted to hurt yourself? [ ] Yes [ ] No

If yes, please describe: _____

Have you ever had thoughts, made statements, or attempted to hurt someone else? [ ] Yes [ ] No

If yes, please describe: _____

Have you ever been physically hurt or threatened by someone else? [ ] Yes [ ] No

If yes, please describe: _____

Therapist's Notes

Past Medical History

Date of last physical exam: _____

Have you experienced any of the following DURING YOUR LIFETIME?

[ ] Allergies	[ ] Asthma	[ ] Headaches	[ ] Stomach aches	[ ] Chronic pain
[ ] Surgery	[ ] Serious accident	[ ] Head injury	[ ] Dizziness/fainting	[ ] Meningitus
[ ] Seizures	[ ] Vision problems	[ ] High fevers	[ ] Diabetes	[ ] Hearing problems
[ ] Chest pain/Angina	[ ] High blood presure	[ ] Heart disease	[ ] Heart attack	[ ] High cholesterol
[ ] Pacemaker	[ ] Kidney stones	[ ] Kidney disease	[ ] Cancer	[ ] Osteoporosis
[ ] Stroke/CVA/TIA	[ ] Seizures	[ ] HIV/AIDS	[ ] Hepatitus	[ ] Stomach ulcer
[ ] Liver disease	[ ] Heart palpitations	[ ] Arthritis	[ ] Heart surgery	[ ] Blood clots
[ ] Tuberculosis	[ ] Depression	[ ] Congestive heart failure	[ ] Thyroid disease	[ ] Glaucoma

Review of Systems

ROS	(-)	Please check all CURRENT positive findings			
Constitutional		[ ] Weight loss	[ ] Fevers	[ ] Chills	[ ] Poor appetite
		[ ] Fatigue	[ ] Insomnia	[ ] Weight gain	[ ] Night sweats
Eyes		[ ] Blurry vision	[ ] Eye pain	[ ] Eye discharge	[ ] Eye redness
		[ ] Decrease in vision	[ ] Dry eyes	[ ] Double vision	[ ] Cataracts
ENT/Mouth		[ ] Sore throat	[ ] Hoarseness	[ ] Ear pain	[ ] Hearing loss
		[ ] Ear discharge	[ ] Nose bleeds	[ ] Sinus problems	[ ] Oral surgery
Cardiovascular		[ ] Chest pain	[ ] Palpitations	[ ] Rapid heart rate	[ ] Heart murmur
		[ ] Poor circulation	[ ] Swelling in legs or feet		
Respiratory		[ ] Shortness of breath	[ ] Chronic cough	[ ] Coughing up blood	[ ] History of tuberculosis
		[ ] Excess sputum production			
Gastrointestinal		[ ] Nausea	[ ] Vomiting	[ ] Diarrhea	[ ] Constipation
		[ ] Blood in stool	[ ] Frequent heartburn/GERD	[ ] Trouble swallowing	[ ] IBS
Genitourinary		[ ] Increased urinary frequency	[ ] Blood in the urine	[ ] Incontinence	[ ] Painful urination
		[ ] Urinary retention	[ ] Abortion		
Skin		[ ] Rash	[ ] Hives	[ ] Hair loss	[ ] Skin sores
		[ ] Itching	[ ] Skin thickening	[ ] Nail changes	[ ] Mole changes
Musculoskeletal		[ ] Joint pain	[ ] Muscle aches	[ ] Frequent leg cramps	[ ] Muscle weakness
		[ ] Joint swelling	[ ] Back pain	[ ] Fibromyalgia	[ ] Motor vehicle accident
Psychiatric		[ ] Anxiety	[ ] Depression	[ ] Alcohol/drug dependence	[ ] Panic attacks
		[ ] ADHD	[ ] Bipolar disorder	[ ] Insomnia	
Endocrine		[ ] Goiter	[ ] Heat intolerance	[ ] Cold intolerance	[ ] Change in skin pigment
		[ ] Increased thirst	[ ] Excess sweating	[ ] Hypothyroidism	[ ] Hyperthyroidism
Neurological		[ ] Seizures	[ ] Tremors	[ ] Migraines	[ ] Numbness
		[ ] Dizziness/vertigo	[ ] Loss of balance	[ ] Stroke	
Hemo/Lymph		[ ] Low blood count	[ ] Easy bruising	[ ] Swollen lymph nodes	[ ] Transfusions
		[ ] Prolonged bleeding	[ ] Blood clots		
Allerg/Immune		[ ] Allergic reactions	[ ] Hay fever	[ ] Frequent infections	[ ] Hepatitus
		[ ] HIV positive	[ ] STD	[ ] Positive tuberculin skin test	

Therapist's Notes

Reviewed by Therapist (initials) _____

Past Mental Health Treatment

Yes	No	Type of Treatment	Date or Age	Provider/Program	Reason for Treatment
		Outpatient Counseling			
		Medication (mental health)			
		Psychiatric Hospitalization			
		Drug/Alcohol Treatment			

Substance Abuse History

Substance Type	Current Use (last 6 months)				Past Use			
	Yes	No	Frequency	Amount	Yes	No	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
Ecstacy								
Heroin/Methadone								
Amphetamines								
Pain killers								
PCP/LSD/Mushrooms								
Steroids								
Tranquilizers								

Have you had withdrawal symptoms when trying to stop using any substances? [ ] Yes [ ] No If yes, please describe:

_____

Have you ever had problems with work, relationships, health, the law, etc. due to your substance use? [ ] Yes [ ] No If yes, please describ

_____

Therapist's Notes

Family Medical History: (Please list any known medical problems)

Father: _____ Mother: _____

Siblings: _____

Your children: _____

Family Mental Health Problems

Type of Problem	Who?	Type of Problem	Who?
Hyperactivity		Panic attacks	
Sexually abused		Obsessive-compulsive	
Depression		Anger/abusive	
Manic depression		Schizophrenia	
Suicide		Eating disorder	
Anxiety		Alcohol/Drug abuse	

Therapist's Notes

Reviewed by Therapist (initials) _____

Family Relationships

Relationship	Name	Age	Quality of Relationship
Mother			
Father			
Stepmother			
Stepfather			
Siblings			
Spouse/partner			
Children			

Family Marital and Developmental History

[ ] Parents legally married or living together [ ] Mother remarried: Number of times _____ [ ] Father remarried: Number of times _____

[ ] Parents temporarily separated [ ] Parents divorced or permanently separated

Developmental History

[ ] Emotional abuse [ ] Neglect [ ] Lived in a foster home [ ] Sexual abuse [ ] Violence in the home

[ ] Multiple family moves [ ] Physical abuse [ ] Crime victim [ ] Homelessness [ ] Parent substance abuse

[ ] Parent illness [ ] Loss of a loved one [ ] Teen pregnancy [ ] Placed a child for adoption [ ] Financial problems

Interpersonal/Social/Cultural Information

Please describe you social support network (check all that apply)

[ ] Family [ ] Neighbors [ ] Friends [ ] Students [ ] Co-workers

[ ] Support/Self-help group [ ] Community group [ ] Religious/Spiritual center (which one?) _____

To which cultural/ethnic group do you belong? _____

If you are experiencing any difficulties due to cultural or ethnic issues, please describe: _____

_____

How important are spiritual matters to you? [ ] Not at all [ ] Little [ ] Somewhat [ ] Very much

Please describe your strengths, skills and talents:

_____

Describe any special areas of interest or hobbies (art, books, physical fitness, etc.):

_____

Therapist's Notes

Reviewed by Therapist (initials) _____

Miscellaneous Information

Employment

Current Employer _____ Position: _____

Length of time in this position _____ Stress level of this position [ ] Low [ ] Medium [ ] High

Previous Employer _____ Position: _____

Length of time in this position _____ Stress level of this position [ ] Low [ ] Medium [ ] High

Previous Employer _____ Position: _____

Length of time in this position _____ Stress level of this position [ ] Low [ ] Medium [ ] High

Previous Employer _____ Position: _____

Length of time in this position _____ Stress level of this position [ ] Low [ ] Medium [ ] High

Education

[ ] Yes [ ] No Are you currently attending school? [ ] High school graduate? [ ] GED? Year _____

[ ] Associate degree Year _____ Major area of study _____

[ ] Undergraduate degree Year _____ Major area of study _____

[ ] Graduate degree Year _____ Major area of study _____

Military Service

[ ] Yes [ ] No Have you been/are currently in the military? (If no, skip the remainder of this section)

Branch _____ Date of discharge _____ Type of discharge _____ Rank _____

[ ] Yes [ ] No Were you in combat?

Legal

[ ] Yes [ ] No Have you ever been convicted of a misdemeanor or felony (including a DUI)? If yes, please explain:

_____

[ ] Yes [ ] No Are you currently involved in any divorce or child custody proceedings? If yes, please explain:

_____

Therapist's Notes

Current Medications [ ] None

Are you allergic to any medications? [ ] Yes [ ] No If yes, please list: _____

Medication	Dosage	Date First Prescribed	Prescribed By

Current Over-the-Counter Medications (including vitamins, herbal remedies, etc.) [ ] None

_____

Allergies and/or adverse reactions to medications [ ] None

_____

Therapist's Notes

Therapist Signature _____