Patient Data
(To be completed by patient)

Name: ____ Age/DOB: ________________
Marital Status: □ single □ separated □ married □ divorced □ living together □ widowed
Spouse/Partner Name: ____

Name of Children	Age	Living with you?
		Yes / No
		Yes / No
		Yes / No
		Yes / No

Briefly describe your reason for contacting us. ____________________________________
____
____
____

Why did you decide to seek help now? ____
____
____

What counseling have you had before? ____
____
____

Was it helpful? ____
What other ways have you tried to handle this problem? __________________________
____
____
____

	not very serious				*very serious*
Overall, how serious is the problem for you?	1	2	3	4	5

How has the problem affected your:

	does not apply	not at all				very much
Marriage/Partner	□	1	2	3	4	5
Family	□	1	2	3	4	5
Job Performance	□	1	2	3	4	5
Friendships	□	1	2	3	4	5
Financial Situation	□	1	2	3	4	5
Health	□	1	2	3	4	5
Legal Situation	□	1	2	3	4	5
Anxiety/Nerves	□	1	2	3	4	5
Mood	□	1	2	3	4	5
Sleep	□	1	2	3	4	5
Eating Habits	□	1	2	3	4	5
Concentration	□	1	2	3	4	5
Parenting	□	1	2	3	4	5
Temper	□	1	2	3	4	5
Spirituality	□	1	2	3	4	5

Primary Care Physician/Clinic: ________________________________ Last visit: ______________
____

Please describe any medical problems. ____
____
____

Please list all over the counter medications you are taking.

Medication:	Frequency:
Medication:	Frequency:
Medication:	Frequency:

Please list all vitamins/herbal supplements you are taking.___________________________
____

Please list all prescription medications you are taking.

Medication:	#mg:	Frequency:
Medication:	#mg:	Frequency:
Medication:	#mg:	Frequency:

Please list all recreational drugs you are taking.

Alcohol:	Frequency:
Marijuana:	Frequency:
Cocaine/Crack:	Frequency:
Heroin:	Frequency:
Other:	Frequency:

Have you had or do you have any of the following:

Yes	*No*	
		Chronic illness (diabetes, asthma, emphysema, high blood pressure, thyroid, hepatitis, etc). If yes, please describe the problem and when and where it is/was treated. ___________________________
		Head injuries/neurological problems (seizures, stroke, MS, MD, etc). If yes, please describe the problem and when and where it is/was treated. ___________________
		Serious medical problems (cancer, heart attack, ulcers, back injuries, chronic pain, etc). If yes, please describe the problem and when and where it is/was treated. ___________________________

Please list all hospitalizations for medical, mental health and chemical dependency issues.

Name of Hospital	Date	Reason for Stay

Please check any of the following symptoms/problems that interfere with your life.

	Poor appetite, weight loss ____ lbs.		Irritability, impatience
	Binge eating, weight gain _____ lbs.		Rage; hit or break objects: yes/no
	Headaches		Rage; hit people: yes/no
	Troubled sleep		Thoughts of suicide
	Crying spells		Plans of suicide
	Inability to cry		Attempted suicide
	Fears, anxiety, panic attacks		Increased use of alcohol/street drugs
	Smoking, packs per day ______		Caffeine use, per day _____
	Daydreaming more than usual		Lack of energy
	Problems with concentration		Self-injurious behavior
	Depressed mood		

Yes	*No*	
		1. Have you in the past year felt you ought to cut down on your drinking or drug use?
		2. Have you in the past year had people annoy you by criticizing your drinking or drug use?
		3. Have you in the past year felt bad or guilty about your drinking or drug use?
		4. Have you in the past year had a drink or used drugs as an eye opener in the morning to steady your nerves or get rid of a hangover or to get started?

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly everyday
Little interest or enjoyment in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling or staying asleep or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself, or that you're a failure/let your family down	0	1	2	3
Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or being so fidgety/restless that you have been moving around a lot more than usual.	0	1	2	3
Thoughts that you would be better off dead or of causing harm to yourself	0	1	2	3

Life Experiences (Circle H for in your history and P for present situation.)

Abusive relationship	H P	Miscarriage	H P	Divorce	H P
Experienced physical abuse	H P	Abortion	H P	Unhappy childhood	H P
Experienced emotional abuse	H P	Crime victim	H P	Family problems	H P
Experienced sexual abuse	H P	War	H P	Few friends	H P
Witnessed physical abuse	H P	Death of a child	H P	Poor academic progress	H P
Witnessed emotional abuse	H P	Death of a parent	H P	Traumatic brain injury	H P
Witnessed sexual abuse	H P	Death of someone close	H P		
Rape	H P	Poverty	H P		

To be completed with your therapist

May your therapist coordinate your care with your primary care doctor? □ Yes □ No
□ I do not have a primary care doctor.
Patient signature ____ Date ______________
Therapist signature ____ Date ______________