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Clinical Information

Name_____Date_____

Who referred you to me?_____

Briefly describe your reason for seeking help now:_____

_____

_____

How intense are these problems for you? (mild) (mild to moderate) (moderate) (moderate to extreme) (extreme)

What do you hope to gain from therapy? _____

_____

_____

Rate any of the following symptoms you are experiencing (1 = low) (2 = medium) (3 = high):

____Easily Irritated
____Extreme Sadness
____Memory problems
____Weight changes
____Self-esteem problems
____Perfectionism
____Problems with anger
____Feeling nervous, worried
____Feeling tearful
____Physical complaints
____Sudden feelings of panic
____Feeling hopeless
____Trouble concentrating
____Lack of energy
____Feeling stressed
____Feeling fearful
____Feeling guilty
____Acting violently
____Muscle tension
____Thoughts of harming yourself or others
____Thoughts of killing yourself or others
____Obsessive thoughts
____Change in sleep patterns
____Change in eating habits
____Extreme happiness
____Change in sexual interest or function
____Difficulty getting along with family
____Trouble performing your job
____Lack of enjoyment of usual activities
____Compulsive behaviors

Have you ever been in therapy before? _____yes _____no
If yes, with whom, when and condition(s) were treated: _____

_____

_____

Was the treatment helpful? Why / why not? _____

_____

_____

Previous psychiatric hospitalizations? _____yes _____no
If yes, please explain (dates, locations, reasons): _____

_____

_____

Clinical Information, con't.

Name of your physician_____Phone:_____

Address: _____

Date of last visit_____Allergies _____

Current and past medical problems and surgeries:_____

_____

_____

Current medications and doses:_____

_____

_____

Please describe the following:

Quantity of cigarette smoking _____

Amount of caffeine (coffee, cola, etc.) _____

Frequency and quantity of alcohol use _____

Frequency and quantity of other substances _____

Frequency and type of physical exercise _____

Amount and quality of sleep _____

Do you consider your use of alcohol/substances to be problematic? _____yes _____no
If yes, please explain your concerns:_____

Are you, or have you ever, been involved in any legal actions? _____yes _____no
If yes, please explain:_____

Job title_____ Employer_____

Work address _____

Highest level of education _____Plans for further education? _____yes _____no

Names and ages of children _____

Other significant persons in your household _____

Emergency contact_____Relationship_____

Address_____

Phone (home)_____(work)_____

Thank you for completing this form.