



Client's Name: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Reason for Seeking Treatment: \_\_\_\_\_

Rate Intensity of Presenting Problem: (None) 0 1 2 3 4 5 6 7 8 9 10 (Most)

Client Information: Please mark appropriate box and explain in space provided (add details).

	<u>Yes</u>	<u>No</u>	<u>Explanation</u>
Normal Energy Level:			_____
Sleep Disturbances:			_____
Appetite Changes:			_____
Exercise:			_____
Anger/Hostility:			_____
Poor Concentration:			_____
Irritability/Agitation:			_____
Mood Swings:			_____
Obsessive Thoughts:			_____
Compulsions:			_____
Anxiety/Tension:			_____
Memory Problems:			_____
Fearfulness:			_____
Hallucinations:			_____
Paranoid Thoughts:			_____
Delusions:			_____
Depressed Mood:			_____
Hopelessness:			_____
Suicidal Thinking:			_____
Homicidal Thinking:			_____
Family/Peer Support:			_____
Social Isolation:			_____

Caffeine Use: \_\_\_\_\_

Cigarette Smoker: \_\_\_\_\_

Alcohol: \_\_\_\_\_  
 Frequency: \_\_\_\_\_  
 Amount: \_\_\_\_\_  
 Last Used: \_\_\_\_\_

Drug Use: \_\_\_\_\_  
 Type(s): \_\_\_\_\_  
 Amount: \_\_\_\_\_  
 Last Used: \_\_\_\_\_

Current Medications

Name	Dosage	Date Began	Prescribed by
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Client's Name: \_\_\_\_\_

	<u>Yes</u>	<u>No</u>	<u>Explanation</u>
Violent Behavior:			_____
Law/Arrest Issues:			_____
Legal Issues:			_____
Prior Therapy:			With Whom: _____ Dates: _____
Prior Psychiatric Treatment:			Where: _____ Dates: _____ Diagnosis: _____
Psychiatric Hospitalization:			Where: _____ When: _____

All General Medical Conditions

Hepatitis:			_____
Thyroid Disease:			_____
AIDS:			_____
Diabetes:			_____
Heart Disease:			_____
Gastrointestinal:			_____
Epilepsy (Seizures):			_____
Migraine Headaches:			_____
Cancer:			_____
Drug Allergies:			List: _____
Other:			_____
Hospitalizations:			Where: _____ When: _____

Family Information

Have members of your family ever had any of the following problems? (parents, grandparents, uncles, aunts, brothers, sisters, and/or children)

Depression:			_____
Anxiety:			_____
Manic Depression/Bipolar:			_____
Suicidal Attempt:			_____
Completed Suicide:			_____
Mental Retardation:			_____
Learning Disability:			_____
Schizophrenia:			_____
Alcohol Abuse:			_____
Drug Abuse:			_____

Highest Education Attained: \_\_\_\_\_

Religious/Faith Orientation: \_\_\_\_\_

Disability (are you presently on disability or have you been in the past?) Explain:

\_\_\_\_\_

\_\_\_\_\_