Name_____ Date_____
Address_____

_____

Preferred Phone number_____ Can I leave a message on this number? Y N Email address_____
With whom do you live?_____Date of Birth _____

I. **Symptoms** - Check all that apply (i.e. if you have felt anxious for as long as you can remember, check all time frames).

Symptom	**Last 2 weeks**	**Last month**	**Last 6 months**	**In your Lifetime**
Dizziness				
Chest pain				
Shortness of breath				
Loss of interest in regular activities				
Decreased energy/fatigue				
Difficulty concentrating				
Difficulty organizing things				
Impulsivity				
Over or under eating				
Decrease appetite				
Using laxatives, diuretics or diet pills to lose weight				
Excessive or compulsive exercise				
Weight loss/gain				
Severe, frequent headaches				
Self-induced vomiting				
Hopelessness				
Emptiness				
Sadness				
Tearfulness				
Guilt				
Anxiety/fear				
Panic				
Intense anger				
Avoidance of public places, crowds				
Intense fear of a particular thing				
Oversleeping				
Under sleeping				

Decreased motivation				
Loss of interest in activities				
Racing thoughts				
Suicidal thoughts				
Suicidal plans or attempts				
Homicidal thought				
Homicidal plans or attempts				

Seeing things others don't see				
Hearing things others don't hear				
Legal trouble				
Destroying property (yours/others)				
Worrying a lot				
Talking unusually fast				
Loneliness/isolation				
Repetitive unwanted thought/actions				
Euphoria, feeling expansive or on top of the world				
Needing very little sleep				
Checking or washing things repeatedly to make sure they're in place or clean				
Recurrent nightmares				
Flashbacks				
Easily startled				
Feeling numb or nothing				
Discomfort with closeness or around other people				
Fear of being abandoned/left				
Difficulty getting along with others or maintaining relationships				
Suspiciousness of others or institutions				
Irritability				
Shifting or lack of sense yourself				
Low self-esteem/opinion of yourself				
Difficulty learning things in school or elsewhere				

Have you ever felt guilty about your use of alcohol/drugs? Y N

Have you ever driven with someone under the influence of drugs or alcohol? Y N

Have you ever felt like you should cut down on your drinking or drug use? Y N

Have people ever annoyed you by their complaining about your drinking/drug use? Y N

How many drinks have you had in the last 2 weeks? _____

Drug	Age of 1-st use	Current Use Amt	Frequency	Last use
alcohol				
pot				
cocaine				
club drugs				
heroin				
Percs/vicoden				
Other prescription				

II. Employment/Education

Are you currently employed? Y N Currently in School? Y N

Highest Level of Education Completed: _____

Current Position and/or Area of Study

_____

_____

How long have you been there? _____
Position/School before this? _____

III. Family

Parents:

Names **Ages** **Primary work type: (indicate if step)**

_____

_____

Siblings: **Ages**

_____

_____

_____

IV. Medical

Your Primary Care Physician: _____
Phone #: _____ Last Physical Date: _____

Your Psychiatrist: _____
Phone#:_____ Last Appt date: _____

Any medical issues? (heart, diabetes, thyroid, menopause, etc.) List, if applicable_____
_____
_____
_____

Currently on any medications? What and what do they treat?

_____
_____
_____
_____
_____

What are your strengths or best qualities?

_____
_____
_____

What do you hope to get out of therapy/Goals for Treatment?

_____
_____
_____
_____

Other things you think it's important for me to know

_____
_____
_____