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Name: _____ SS#: _____ Age/DOB: _____

Marital Status: S M Sep D W

Presenting Problem: _____

Are you having problems in any of the following areas? How long? How severe?

Sleep	Appetite	Energy	Concentration
Mood	Pain	Suicide	Anxiety/Panic

Last physical exam: _____ Health Problems: _____

Previous therapy:

<u>Dates</u>	<u>Therapist</u>	<u>Reason</u>	<u>Why Ended</u>
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL HISTORY (If yes, check box & write past or present)

- | | | |
|--|---|---|
| <input type="checkbox"/> Headache _____ | <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Arthritis _____ |
| <input type="checkbox"/> Head injury _____ | <input type="checkbox"/> Appetite/Weight Change _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Loss of Consciousness _____ | <input type="checkbox"/> Thyroid Problems _____ | <input type="checkbox"/> Skin problems _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Vision problems _____ |
| <input type="checkbox"/> Shortness of breath _____ | <input type="checkbox"/> Kidney Disease _____ | <input type="checkbox"/> Hearing problems _____ |
| <input type="checkbox"/> Allergies/Hay fever _____ | <input type="checkbox"/> Urinary Problems _____ | <input type="checkbox"/> Polio _____ |
| <input type="checkbox"/> Heart problems _____ | <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Abnormal Lab Tests _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Withdrawal Seizures _____ | <input type="checkbox"/> Sexual Problems _____ |
| <input type="checkbox"/> GI disorder _____ | <input type="checkbox"/> Frequent Infections _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Constipation _____ | <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Diarrhea _____ | <input type="checkbox"/> Allergies to medications- names and reactions: _____ | |

WOMEN ONLY

Currently Pregnant? Yes No

Planning pregnancy? Yes _____ No _____

Regular Menstrual Cycles? Yes No

Date of Last PAP? _____

MEN ONLY

It's common for men to occasionally experience erection difficulties. Is this something that happens to you? Yes No

How often does this occur? Frequently Sometimes Rarely

HABITS

Smoke: Packs Daily _____ Coffee: Cups daily: _____ Sleep: Difficulty falling asleep _____

How long? _____ Other caffeine _____ Difficulty staying asleep _____

Tried stopping? _____ Alcohol/Drugs: Type: _____ Snoring _____

Exercise: What kind _____ Amount daily: _____ Early morning awakening _____

Minutes per day _____ Amount Weekly: _____ Special Diet: _____

Days per week _____

Medications

(For Office Use)

Facial Expression: sad /flat /hostile/ avoids gaze /frightened /anxious /angry /sullen /defiant /laughing /wooden /animated /unremarkable /other

Appearance/Dress: meticulous /poor hygiene /eccentric /seductive /ethnic /theatrically stylish /expensive /disheveled /careless / other

Speech: excessive /reduced /pressured /slowed /loud /soft /muted /slurred /stuttering /heavily accented / unmodulated / other

Behavior: irritable /angry outbursts /impulsive /hostile /silly /sensitive /apathetic /withdrawn /evasive /passive / aggressive /naïve / overly dramatic / manipulative /helpless /uncooperative /demanding /negative /oppositional /callous /cooperative /grandiose /defensive /bored /other

Flow of Thoughts: blocking /halting /circumstantial /tangential /perseverating /flight of ideas /loose associations /indecisive /distractible /storytelling / other

Content of Thoughts: flight of ideas /ideas of reference /suicidal /assaultive /homicidal /somatic /hypochondriacal /suspicious / impoverished /fears / obsessions / compulsions /unreality /persecution /running away /guilt /hopelessness /worthlessness / religiosity / sexual /blaming / other

Mood/Affect: overt anger /suppressed anger /anxious /flat affect /tearful /sobbing /depressed /elevated /labile /expansive /irritable /overwhelmed /other

Provisional Diagnosis: _____

Treatment Plan: _____
