CLIENT REPORT OF PROBLEM

Name _____ **Today's Date** _____ **Case #** _____

Briefly describe your reason(s) for seeking help

How long have you had the problem(s)?

Why did you decide to seek help now?

What other ways have you tried to deal with this problem?

History of treatment for emotional problems and family history

Outpatient treatment ☐ yes ☐ no
Did it help ☐ yes ☐ no

Therapist's name _____
Dates in treatment _____

Inpatient treatment ☐ yes ☐ no

Where _____

When _____

How long _____

Family history of emotional problems ☐ yes ☐ no

Who _____

Relationship to you _____

Check any of the following items that apply to you:

☐ Thoughts of suicide
☐ Trouble getting to sleep
☐ Waking during the night
☐ Waking early every day
☐ Financial problems
☐ Loss of appetite
☐ Hearing voices
☐ Problems at work
☐ Trouble concentrating
☐ Racing thoughts
☐ Legal problems

☐ Thoughts of harming others
☐ History of attempts to kill yourself
☐ Cutting or otherwise hurting yourself
☐ Feelings of hopelessness
☐ Inability to make decisions
☐ Trouble controlling your temper
☐ Large weight gain or loss
☐ Seeing things others don't
☐ History of physical abuse
☐ History of sexual abuse

☐ Phobias
☐ Panic attacks
☐ Excessive quilt
☐ Forgetfulness
☐ Mood swings
☐ Health problems
☐ Family problems
☐ Violence toward others
☐ Tingling or numbness
☐ Depressed mood

(Please complete the other side of this form)

Health Status

List any medical problems or physical problems and when they were diagnosed

1.
2.
3.

List any major (where you were put to sleep) surgeries you have had to date

1.
2.
3.

List any serious illness or injuries especially anything involving the head

1.
2.
3.

List ***any*** allergies to foods or drugs

1. 3.
2. 4.

Date of last physical examination _____ Doctor's name _____

May we contact your doctor? ☐ yes ☐ no

Drug and Alcohol Information

List all of the prescription and over-the-counter drugs you are taking

Check substances you use <u>in any amount at</u> all	Age first used	**How much do you use per** Weekday	Weekend	Month	Last used
☐ Beer	_____	_____	_____	_____	_____
☐ Liquor	_____	_____	_____	_____	_____
☐ Wine	_____	_____	_____	_____	_____
☐ Marijuana	_____	_____	_____	_____	_____
☐ Cocaine/Crack	_____	_____	_____	_____	_____
☐ Methamphetamine/Crystal	_____	_____	_____	_____	_____
☐ Heroin	_____	_____	_____	_____	_____
☐ Barbiturates (downers)	_____	_____	_____	_____	_____
☐ PCP, LSD (Hallucinogens)	_____	_____	_____	_____	_____
☐ Tobacco (in any form)	_____	_____	_____	_____	_____
☐ Other _____	_____	_____	_____	_____	_____

To be completed by adults (18 yrs and older)

Have you ever felt like you should cut down on your drug or alcohol use? ☐ yes ☐ no
Has a friend or relative expressed concerns about your use? ☐ yes ☐ no
Have you ever felt guilty about your drinking or drug use? ☐ yes ☐ no
Have you ever had to take a drink or use a drug the next day to steady your nerves? ☐ yes ☐ no
Are you a recovering alcoholic or a recovering drug addict? ☐ yes ☐ no
Is there a history of problems with drug or alcohol use in your family? ☐ yes ☐ no

To be completed by adolescents (12 yrs to 17 yrs)

Have you ever used alcohol or drugs before or during school? ☐ yes ☐ no
Have you ever missed school (or been truant) because of use or just to use? ☐ yes ☐ no
Have you ever avoided non-users? ☐ yes ☐ no
How often do you get drunk/high? _____
About how often do you use more than one drug when you get high? _____
Is there a history of problems with drug or alcohol use in your family? ☐ yes ☐ no

_____ _____

Therapist Date Client signature Date