|  |
| --- |
| **SERVICE LOCATION** (check all that apply)**:** [ ]  Video-Therapy  [ ]  Nursing Home [ ]  Office **WHO REFERRED YOU?**  [ ]  Web Search [ ]  Friend [ ]  Psychology Today [ ]  Physician Name: \_\_\_\_\_\_\_ [ ]  Other \_\_\_\_\_\_\_ |

|  |
| --- |
| **PERSONAL INFORMATION** |
| Last Name:       First Name:       Middle Initial: \_\_\_\_\_\_\_ Gender:  Date of Birth:     /    /      SSN:       -       -       E-Mail:      Address:       City:      State:     Zip Code:      May we send mail to this address? [ ]  Yes [ ]  NoHome Phone:      -     -      Work Phone:      -     -      Cell Phone:      -     -     Preferred call number?  May we leave a private voicemail at your preferred call number? [ ]  Yes [ ]  NoMarital Status:  Preferred Language:  Religion:  Race: Where Do You Live:  |
| **NAME OF RELATIVES/SIGNIFICANT OTHERS** | **LIVES W/ CLIENT** | **RELATIONSHIP** | **D.O.B. & AGE** |
|       | **[ ]  Yes** **[ ]  No** |       |       |
|       | **[ ]  Yes [ ]  No** |       |       |
|       | **[ ]  Yes [ ]  No** |       |       |
|       | **[ ]  Yes [ ]  No** |       |       |
|       | **[ ]  Yes [ ]  No** |       |       |
| **FAMILY/EMERGENCY CONTACT** |
| Name:      Relationship:       Phone:      -     -      Address:       City:      State:     Zip Code:      Is this your Guardian/Substitute Decision Maker?[ ]  Yes [ ]  No |
| **REASON FOR VISIT** |
|  |
| **MEDICAL INSURANCE INFORMATION** [ ]  SELF-PAY [ ]  APPLYING FOR REDUCED FEE |
| **PRIMARY INS.** **CARRIER:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SUBSCRIBER ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP: \_\_\_\_\_\_\_\_\_\_\_\_\_ IS CLIENT THE INSURANCE SUBSCRIBER: YES [ ]  NO [ ]  IF “NO”, RELATIONSHIP TO SUBSCRIBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SUBSCRIBER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SUBSCRIBER EMPLOYER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**SECONDARY INS. CARRIER:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SUBSCRIBER ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP: \_\_\_\_\_\_\_\_\_\_\_\_\_ IS CLIENT THE INSURANCE SUBSCRIBER: YES [ ]  NO [ ]  IF “NO”, RELATIONSHIP TO SUBSCRIBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SUBSCRIBER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SUBSCRIBER EMPLOYER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| SYMPTOMS CHECKLIST – CHECK THE BOX NEXT TO SYMPTOMS YOU HAVE EXPERIENCED IN THE PAST 2 WEEKS |
| **General**[ ]  Anxiety [ ]  Panic attacks [ ]  Constant Worry [ ]  Crying spells [ ]  Sad mood [ ]  Fatigue [ ]  Lack motivation [ ]  Irritable [ ]  Nightmares [ ]  Flashbacks of traumatic events [ ]  Hearing things others can’t hear [ ]  Seeing things others can’t see **Relationships (Familial & Social)**[ ]  Arguing with family (more than usual) [ ]  Physically aggressive [ ]  Arguing with friends (more than usual) [ ]  Communication difficulties [ ]  Isolating [ ]  Not enjoying things which I used to enjoy (Anhedonia)**Activities of Daily Living**[ ]  Not bathing and/or brushing your teeth [ ]  Lack energy and/or motivation to wash clothes and/or clean house[ ]  Decreased appetite [ ]  Not eating/skipping meals [ ]  Sleeping too much [ ]  Not sleeping [ ]  Difficulty getting out of bed [ ]  Staying in bed all day [ ]  Nightmares **Functioning (Work, School)**[ ]  Difficulty concentrating (more than usual) [ ]  Difficulty completing tasks [ ]  Calling in sick How often?      [ ]  Performance difficulties at work [ ]  Performance Difficulties at School  **Other Symptoms (please use the space below to fill in symptoms not listed on the checklist above.)**     **Did something(s) happen to cause the symptoms? If so, what happened and when?** **.** |

|  |
| --- |
| **RISK OF HARM ASSESSMENT** |
| **Have you had *thoughts* of harming yourself in the past 2 weeks?** [ ]  No [ ]  YES If yes, please answer the following questions?1. Have you thought of how you might harm yourself? [ ]  No [ ]  YES If yes, how?
2. Do you now have or in the past two weeks have you had *intentions* to harm yourself? [ ]  No [ ]  YES
3. Have you actually tried to hurt yourself? [ ]  No [ ]  YES If yes, please provide the following information:

 *When* was the last time you attempted or actually harmed yourself?       *How*?       *Why* did you self-harm? I cut/harm myself to: (check one or both) [ ]  numb emotional pain [ ]  kill myself**Have you had *thoughts* of harming others in the past 2 weeks?** [ ]  No [ ]  YES If yes, please answer the following questions?1. Have you thought of how you might harm others? [ ]  No [ ]  YES If yes, how?
2. Do you now have or in the past two weeks have you had *intentions* to harm others? [ ]  No [ ]  YES
3. Have you actually tried to harm others? [ ]  No [ ]  YES If yes, please provide the following information:

 *When* was the last time you attempted or actually harmed someone?       *How*?       *Why* did you harm someone       |
| **HISTORY OF MENTAL HEALTH**  |
| 1. How long have you been experiencing your current symptoms?
2. Have you ever experienced these symptoms in the past? [ ]  No [ ]  YES If yes, did you receive treatment? [ ]  No [ ]  YES
3. If you have seen a health care professional for mental health reasons, whom did you see?
4. What treatment did you receive? Check all that apply: [ ]  Medication [ ]  Counseling/Therapy [ ]  Hospitalization

Date(s) of treatment:       What diagnosis did you receive?      1. Was the treatment you received helpful? [ ]  No [ ]  YES
2. What level of recovery did you receive from previous treatment?

[ ]  Fully recovered [ ]  Mostly recovered [ ]  Somewhat recovered [ ]  Treatment did not help at all |
| **FAMILY HISTORY**  |
| 1. How long have you been married       , divorced      , or widowed      ?
2. Is your mother living? [ ]  Yes [ ]  No If no, when did she die?
3. Is your father living? [ ]  Yes [ ]  No If no, when did he die?
4. Do you have any siblings? [ ]  Yes [ ]  No If yes, what are their names and ages?
5. Who in your family is supportive of you?
6. Has anyone in your immediate and extended family been diagnosed with a mental illness? [ ]  No [ ]  YES

If yes, what?      1. Has anyone in your immediate and extended family been treated for substance abuse? [ ]  No [ ]  YES

If yes, who?       |
| **SOCIAL & OCCUPATIONAL HISTORY** |
| 1. What is the name of your employers/school?
2. If you are a student, what grade are you in?      , and what type of grades do you usually get?
3. If you are employed, have you always had the same type of job? [ ]  Yes [ ]  No If no, what other jobs have you had?

     1. Has your present symptoms/illness impacted your performance at work/school? [ ]  No [ ]  YES

If yes, how?      1. What types of activities do you normally enjoy for fun?
2. How has your involvement in, and enjoyment of, your usual social activities changed since your present troubles began?

      |