Tim F. Fitsimones, M.A., LMHC, CAP

Professional Counseling Services
P.O. Box 82 Licensed Mental Health Counselor Ph: 407-629-7114
Winter Park, FL 32790 Certified Addictions Professional Fax 407-629-7463

CLIENT NAME: _____DATE:_____

Please indicate how you are affected by each item below by circling the appropriate number. Circle one number for each category.

Not a Problem - 1	A Slight Problem - 2	A Moderate Problem – 3	A Serious Problem - 4	A Severe Problem - 5

YOUR PHYSICAL FUNCTIONS

Sleep Pattern	1 2 3 4 5	1
Eating Pattern	1 2 3 4 5	1
Bladder Control	1 2 3 4 5	1
Bowel Control	1 2 3 4 5	1
Seizures or Convulsions	1 2 3 4 5	1
Speech (stutter or stammer)	1 2 3 4 5	1
Weight Problem	1 2 3 4 5	1
Sexual Functioning	1 2 3 4 5	1

Other _____

YOUR EXPERIENCE AT WORK

General Performance	1 2 3 4 5	1
Absenteeism	1 2 3 4 5	1
Relating to Supervisors	1 2 3 4 5	1
Relation to Co-Workers	1 2 3 4 5	1

Other _____

YOUR BEHAVIOR

Difficulty with Daily Routine	1 2 3 4 5	1
Letting Other Take Advantage of you	1 2 3 4 5	1
Hyperactivity (can't sit still)	1 2 3 4 5	1
Repeating Certain Acts, again & again	1 2 3 4 5	1
Physically Abusing Others	1 2 3 4 5	1
Using Alcohol to Cope with Problems	1 2 3 4 5	1
Using Drugs to Cope with Problems	1 2 3 4 5	1
Lying	1 2 3 4 5	1
Stealing	1 2 3 4 5	1
Withdrawal from Others Socially	1 2 3 4 5	1
Dependency (relying on others to make your decisions and take care of you)	1 2 3 4 5	1
Suspiciousness (questioning others motives)	1 2 3 4 5	1
Hostility (getting angry towards others)	1 2 3 4 5	1

Other _____

YOUR FEELINGS & MOODS

Depression (sadness)	1 2 3 4 5	1
Euphoria (feeling "high")	1 2 3 4 5	1
Sudden Changes in Mood for No Apparent Reason	1 2 3 4 5	1
Anxiety (nervousness)	1 2 3 4 5	1
Lack of Energy	1 2 3 4 5	1
Feeling Angry	1 2 3 4 5	1
Not Liking Self	1 2 3 4 5	1
Not Liking Others	1 2 3 4 5	1

Others _____

YOUR INNER THOUGHTS & IDEAS

Thoughts about Hurting Yourself	1 2 3 4 5	1
Having Unwanted Thoughts	1 2 3 4 5	1
Worrying about Your Health	1 2 3 4 5	1
Believing You are Inferior to others	1 2 3 4 5	1
Believing You are Better than others	1 2 3 4 5	1
Seeing things without apparent cause	1 2 3 4 5	1
Hearing things without apparent cause	1 2 3 4 5	1
Experiencing Confusion	1 2 3 4 5	1
Memory	1 2 3 4 5	1

Other _____

INDICATE IF YOU ARE CURRENTLY EXPERIENCING ANY OF THE FOLLOWING HEALTH PROBLEMS:

☐ Abdominal Pain	☐ Colitis	☐ Hearing Problems
☐ Backache	☐ Cough	☐ Hypertension
☐ Change in Bowel Habits	☐ Difficulty Sleeping	☐ Hypoglycemia
☐ Change in Menstrual Pattern	☐ Eye Problems	☐ Loss of Sexual Interest
☐ Change in Urinary Pattern	☐ Gastro-Intestinal Problems	☐ Loss or Increase in appetite
☐ Chest Pain	☐ Headache	☐ Palpitations
☐ Problems with skin	☐ Shortness of Breath	☐ Ulcers
☐ Vomiting	☐ Problems with Muscles, Joints, Bones OTHER:_____	

Have you ever been confined to a psychiatric hospital? Yes ☐ No☐ If yes, list name of hospital and date(s) _____
Have you ever tried to commit suicide? Yes ☐ No☐ _____
Have you ever tried to harm someone else? Yes ☐ No☐_____

Please list medications and dosage you are now using even if occasionally, and for what purpose you take them:

Medications & Dosage _____

_____

PERSONAL PHYSICIAN:_____ADDRESS:_____

PHONE: _____Date of Last Physical Exam:_____ I give consent for you to contact my doctor and obtain records yes no

HAVE ANY OF YOUR RELATIVES HAD:

Alcoholism	Drug Dependency
Cardiac Problems	Mental/Emotional Problems
Diabetes	High Blood Pressure

Other _____

INDICATE THE AMOUNTS OF THE FOLLOWING SUBSTANCES YOU USE ON A DAILY BASIS**:**

Alcohol _____ Tea _____ Coffee _____
Tobacco _____ Drugs _____ Other _____

_____ _____
Signed **Date**