My Current Treatment Team

Primary Care Physician:	Phone:
Psychiatrist:	Phone:
Mental Health therapist:	Phone:
Dietitian:	Phone:
Personal trainer:	Phone:
Other providers:	

My Previous Mental Health Treatment

Types of mental health treatment I have received (check all that apply):

- ☐ Psychotropic medication
- ☐ Individual counseling
- ☐ Family counseling
- ☐ Couples' counseling
- ☐ Intensive outpatient program
- ☐ Day treatment program
- ☐ Inpatient psychiatric program
- ☐ Residential treatment program
- ☐ Other:

My Previous Mental Health Counselors, Therapists or Psychiatrists (if any):

Provider Name	Years

My Psychotropic Medications *(if any)*

Current Medications	Previous Medications I have tried

Symptoms I have had in recent months (page 1 of 3) *(check all that apply)*

- ☐ Low resistance to illness Details:
- ☐ Generally feeling “not well” Details:
- ☐ Fatigue, lethargic or low energy Details:
- ☐ See or hear things others do not Details:
- ☐ Loss of physical strength Details:
- ☐ Loss of physical endurance Details:
- ☐ Problems with hearing or vision Details:
- ☐ Ringing in the ears Details:
- ☐ Difficulty swallowing Details:
- ☐ Tooth or gum problems Details:
- ☐ Neck pain or stiffness Details:
- ☐ Chest pain or tightness Details:
- ☐ Difficulty breathing Details:
- ☐ Swelling of the hands or feet Details:
- ☐ High blood pressure Details:
- ☐ Frequent episodes of heartburn Details:
- ☐ Frequent episodes of gas or bloating Details:
- ☐ Frequent episodes of nausea Details:
- ☐ Frequent episodes of abdominal pain Details:
- ☐ Unintentional vomiting Details:
- ☐ Use of laxatives Details:
- ☐ Frequent episodes of constipation Details:
- ☐ Frequent episodes of diarrhea Details:
- ☐ Discomfort with heat or cold Details:
- ☐ Sudden sensations of heat or feeling flush Details:
- ☐ Excessive sweating (not during exercise) Details:
- ☐ Joint pain Details:
- ☐ Muscle tension or pain Details:
- ☐ Muscle spasms, twitching or tics Details:
- ☐ Tension headaches Details:
- ☐ Migraine headaches Details:
- ☐ Shakiness Details:

Symptoms I have had in recent months (page 2 of 3) *(check all that apply)*

- ☐ Numbness in certain body areas Details:
- ☐ Dizziness or lightheadedness Details:
- ☐ Difficuly with balance of coordination Details:
- ☐ Blackouts or fainting spells Details:
- ☐ Seizures or pseudoseizures Details:
- ☐ Poor memory Details:
- ☐ Difficulty keeping track of time Details:
- ☐ Poor concentration Details:
- ☐ Confusion Details:
- ☐ Short attention span Details:
- ☐ Menstruation problems (women only) Details:
- ☐ Loss of interest in things I normally like Details:
- ☐ Loss of sex drive Details:
- ☐ Difficulty with sexual performance Details:
- ☐ Low self-esteem Details:
- ☐ Difficulty falling asleep at night Details:
- ☐ Waking up frequently at night Details:
- ☐ Thoughts about death Details:
- ☐ Urges to cause physical harm to people Details:
- ☐ Urges to cause damage to my own body Details:
- ☐ Thoughts about suicide Details:
- ☐ Avoidance of people or social situations Details:
- ☐ Increased appetite Details:
- ☐ Decreased appetite Details:
- ☐ Anxiety or excessive worry Details:
- ☐ Suspicious of other people Details:
- ☐ Strong fear or sense of impending doom Details:
- ☐ Rapid heart rate Details:
- ☐ Irritability Details:
- ☐ Outbursts of anger or rage Details:
- ☐ Mood swings Details:
- ☐ Overwhelming feelings of sadness Details:

Symptoms I have had in recent months (page 3 of 3) *(check all that apply)*

- ☐ Tearfulness or crying spells Details:
- ☐ Feelings that I am a failure Details:
- ☐ Tendency to be easily distracted Details:
- ☐ Sensitive about my physical appearance Details:
- ☐ Feelings of hopelessness Details:
- ☐ Feelings of helplessness Details:
- ☐ Drinking alcohol in excess Details:
- ☐ Use of illegal substances Details:
- ☐ Misuse of medication Details:
- ☐ Overeating or bingeing Details:
- ☐ Self-induced vomiting Details:
- ☐ Restrictive dieting or self-starvation Details:
- ☐ Fear of specific objects or situations Details:
- ☐ Difficulty expressing emotions Details:
- ☐ Feelings of inadequacy Details:
- ☐ Impulsive behavior Details:
- ☐ Sensitive to criticism from others Details:
- ☐ Feeling overly dependent on others Details:
- ☐ Perfectionistic expectations of self Details:
- ☐ Preoccupation with keeping things clean Details:
- ☐ Preoccupation with keeping things orderly Details:
- ☐ Feeling compelled to do certain behaviors Details:
- ☐ Feelings of guilt or regret Details:
- ☐ More talkative or pressure to keep talking Details:
- ☐ Feeling of elation, euphoric, full of energy Details:
- ☐ Thoughts racing through my mind Details:
- ☐ Flashbacks or preoccupation with the past Details:
- ☐ Feelings of discouragement Details:
- ☐ Problems with performance at work Details:
- ☐ Problems with performance at school Details:
- ☐ Conflicts in relationships with others Details:
- ☐ Other:

My degree of stress in general life areas

Health/Fitness:	choose one	Details:
Spiritual/Religious:	choose one	Details:
Sisters/Brothers:	choose one	Details:
Parents:	choose one	Details:
Romance/Marriage:	choose one	Details:
Children:	choose one	Details:
Friendships:	choose one	Details:
School:	choose one	Details:
Job/Career:	choose one	Details:
Financial/Legal:	choose one	Details:

I manage my stress by using *(check all that apply)*

- ☐ Exercise
- ☐ Spending time with people
- ☐ Spending time with pets
- ☐ Meditation / Prayer
- ☐ Reading
- ☐ Arts & Crafts
- ☐ Outdoor recreation
- ☐ Other:

I would describe my current financial status as *(check one)*

choose one

My experience with legal matters *(check all that apply)*

- ☐ Victim of a crime
- ☐ Accused of a crime
- ☐ Convicted of a crime
- ☐ Witness to a crime
- ☐ Plaintiff in a lawsuit
- ☐ Defendant in a lawsuit
- ☐ Other:

I have experienced discrimination due to *(check all that apply)*

- ☐ Age
- ☐ Race
- ☐ Sex
- ☐ Weight
- ☐ Religion
- ☐ Sexual orientation
- ☐ Other:

I have experienced disabilities *(list them here)*

When my mother was pregnant with me:

choose one

My age and details of my adoption *(leave blank if not adopted)*:

Tasks I had difficulty with as a child *(check all that apply):*

- ☐ Sitting up
- ☐ Crawling
- ☐ Walking
- ☐ Talking
- ☐ Toilet training
- ☐ Feeding
- ☐ Dressing
- ☐ Other:

My ethnic background is *(check all that apply):*

- ☐ African American
- ☐ Asian
- ☐ Caucasian
- ☐ Hispanic
- ☐ Native American
- ☐ Pacific Islander
- ☐ Other:

My religion is:

choose one

I would classify my religious activity as:

choose one

I would classify my sexual orientation as:

choose one

I would classify my gender expression as:

choose one

My marital status is:

choose one

My Father's Father *(paternal grandfather)*

Name:

Age: If deceased, age at death: Year of death:

Cause of death:

Occupation:

Medical problems:

Psychological problems:

Alcohol or drug problems:

My Father's Mother *(paternal grandmother)*

Name:

Age: If deceased, age at death: Year of death:

Cause of death:

Occupation:

Medical problems:

Psychological problems:

Alcohol or drug problems:

My Mother's Father *(maternal grandfather)*

Name:

Age: If deceased, age at death: Year of death:

Cause of death:

Occupation:

Medical problems:

Psychological problems:

Alcohol or drug problems:

My Mother's Mother *(maternal grandmother)*

Name:

Age: If deceased, age at death: Year of death:

Cause of death:

Occupation:

Medical problems:

Psychological problems:

Alcohol or drug problems:

My Father's Brothers *(paternal uncles)*

Name: Age: Occupation: Medical/psych/alcohol/drugs: If deceased, when/how:

My Father's Sisters *(paternal aunts)*

Name: Age: Occupation: Medical/psych/alcohol/drugs: If deceased, when/how:

My Mother's Brothers *(maternal uncles)*

Name: Age: Occupation: Medical/psych/alcohol/drugs: If deceased, when/how:

My Mother's Sisters *(maternal aunts)*

Name: Age: Occupation: Medical/psych/alcohol/drugs: If deceased, when/how:

My Father

Name:

Age: If deceased, age at death: Year of death:

Cause of death:

Occupation:

Medical problems:

Psychological problems:

Alcohol or drug problems:

My Mother

Name:

Age: If deceased, age at death: Year of death:

Cause of death:

Occupation:

Medical problems:

Psychological problems:

Alcohol or drug problems:

My Stepfather *(if any)*

Name:

Age: If deceased, age at death: Year of death:

Cause of death:

Occupation:

Medical problems:

Psychological problems:

Alcohol or drug problems:

My Stepmother *(if any)*

Name:

Age: If deceased, age at death: Year of death:

Cause of death:

Occupation:

Medical problems:

Psychological problems:

Alcohol or drug problems:

My Brothers *(biologically related)*

Name: Age: Occupation: Medical/psych/alcohol/drugs: If deceased, when/how:

My Sisters *(biologically related)*

Name: Age: Occupation: Medical/psych/alcohol/drugs: If deceased, when/how:

My Step or Adopted Brothers *(if any)*

Name: Age: Occupation: Medical/psych/alcohol/drugs: If deceased, when/how:

My Step or Adopted Sisters *(if any)*

Name: Age: Occupation: Medical/psych/alcohol/drugs: If deceased, when/how:

My current relationship *(if any)*

Name:

Age:

Type of relationship: choose one In the relationship since (month or year):

Occupation:

Medical problems:

Psychological problems:

Alcohol or drug problems:

My previous marriages / significant relationships *(if any)*

Name:	Age:	Occupation:	Medical/psych/alcohol/drugs:	If deceased, when/how:

My Children *(biologically related, if any)*

Name:	Age:	Occupation:	Medical/psych/alcohol/drugs:	If deceased, when/how:

My Step or Adopted children *(if any)*

Name:	Age:	Occupation:	Medical/psych/alcohol/drugs:	If deceased, when/how:

My friends *(check all that apply)*:

- ☐ I have many friends
- ☐ I have a few close friends
- ☐ I have no close friends
- ☐ My friends are supportive
- ☐ Friendships are superficial
- ☐ Friendships are stressful
- ☐ It's difficult to make friends
- ☐ I used to have more friends
- ☐ I have more friends than ever
- ☐ Other:

The people who are my best supports:

Name	Age	Relationship

The people who make things more difficult for me:

Name	Age	Relationship

The people I live with now:

Name	Age	Relationship

I grew up with *(check all that apply)*:

- ☐ My biological parents
- ☐ A biological parent & a stepparent
- ☐ Single parent
- ☐ Adoptive parent(s)
- ☐ Divorced parents - shared custody
- ☐ Foster parents
- ☐ Siblings
- ☐ Step or adopted siblings
- ☐ Pets
- ☐ Other:

The places I've lived *(start with your hometown and list all moves)*:

Age City Reason for moving here

The place I live now:

choose one

The level of satisfaction about my current living environment:

choose one

My experience with military service *(leave blank if never served)*:

Branch of Service:

Years in Service:

Deployment Details:

Relevant experiences:

When I have time for recreational activities, I enjoy *(list activities)*:

The education level I have COMPLETED

choose one

The education level I PLAN to achieve

choose one

The schools I have attended

Middle school:		Grades: choose one
High school:		GPA: choose one
College:		GPA: choose one
Graduate/Medical school:		GPA: choose one

During school, I was involved in *(check all that apply)*

- ☐ Athletics/sports Details:
- ☐ Clubs/organizations Details:
- ☐ Student government Details:
- ☐ Honors/AP classes Details:
- ☐ Resource classes Details:
- ☐ Private school Details:
- ☐ Home school Details:

Problems I had in school *(check all that apply)*

- ☐ Learning difficulties Details:
- ☐ Behavioral problems Details:
- ☐ Attendance problems Details:
- ☐ Conflict with peers Details:
- ☐ Conflict with teachers Details:
- ☐ Held back a grade Details:
- ☐ Other Details:

Other school related issues

About my current employment *(check all that apply)*

- ☐ Full time student Details:
- ☐ Part time job Details:
- ☐ Full time job Details:
- ☐ Homemaker Details:
- ☐ Retired Details:
- ☐ Unemployed Details:
- ☐ Disabled Details:
- ☐ Other Details:

My current job

Job Title	Company Name	Years

I would rate my current job satisfaction

choose one Details:

Problems with my current job *(check all that apply)*

- ☐ Attendance problems Details:
- ☐ Conflict with coworkers Details:
- ☐ Poor relations w/ boss Details:
- ☐ I don't enjoy the work Details:
- ☐ Promotion unlikely Details:
- ☐ Not my field of interest Details:
- ☐ Other Details:

Previous jobs I have had

Job Title	Company Name	Years

My history with substances

Tobacco: choose one — If in the past, when?

Alcohol: choose one — If in the past, when?

Drugs: choose one — If in the past, when?

I believe my use of substances *(check all that apply)*

- ☐ Has not been a problem in any significant way.
- ☐ Has been a reasonable method for fun, recreation and entertainment.
- ☐ Has been a way for me to cope with emotions or stress in my life.
- ☐ Has caused me medical or mental health problems.
- ☐ Has caused me legal or financial problems.
- ☐ Has caused me problems with relationships.
- ☐ Has caused me problems with employment.

Current use patterns *(if any)*

Beer:	choose one	choose one	Cigarettes:	choose one	choose one
Wine:	choose one	choose one	Cigars:	choose one	choose one
Mixed drinks:	choose one	choose one	Chewing tobacco:	choose one	choose one
Liqour shots:	choose one	choose one			

Illegal drugs I have tried in the past or present *(if any)*

- ☐ Marijuana
- ☐ Heroin/IV opiates
- ☐ Oral opiates
- ☐ Cocaine
- ☐ Hallucinogens
- ☐ Inhalants
- ☐ MDMA/Ecstacy
- ☐ Stimulants
- ☐ Anabolic Steroids
- ☐ Synthetics
- ☐ Benzodiazapines
- ☐ Other

I have used prescription medications *(check all that apply)*

- ☐ At times, I have used prescription medication in greater doses than prescribed to me.
- ☐ At times, I have used prescription medication that was not prescribed to me.
- ☐ At times, I have used prescription medication to get “high” or intoxicated.
- ☐ At times, I have used over the counter medication inappropriately.

Other substance use details

I would rate my current physical fitness

Cardiovascular fitness:	choose one	Details:
Physical endurance:	choose one	Details:
Exercise frequency:	choose one	Details:
Upper body strength:	choose one	Details:
Upper body flexibility:	choose one	Details:
Lower body strength:	choose one	Details:
Lower body flexibility:	choose one	Details:
Nutrition quality:	choose one	Details:
Body weight:	choose one	Details:
Body composition:	choose one	Details:
Blood pressure:	choose one	Details:
Resting heart rate:	choose one	Details:
Sleep quality:	choose one	Details:
Stress management:	choose one	Details:
Relaxation practices:	choose one	Details:

I would rate my current physical appearance

Face:	choose one	Details:
Hair:	choose one	Details:
Smile:	choose one	Details:
Voice:	choose one	Details:
Skin complexion:	choose one	Details:
Shoulders:	choose one	Details:
Back:	choose one	Details:
Chest:	choose one	Details:
Abdomen:	choose one	Details:
Arms:	choose one	Details:
Hands & Fingers:	choose one	Details:
Hips & Waist:	choose one	Details:
Buttocks:	choose one	Details:
Thighs:	choose one	Details:
Calves & Ankles:	choose one	Details:
Feet & Toes:	choose one	Details: