Patient Name: ______________________________ **Date:** ________________

Check any of the symptoms that you (or your child if applicable) are experiencing:

☐ Depression	☐ Feeling hopeless	☐ Lack of enjoyment of usual activities	☐ Feeling Stressed
☐ Extreme Sadness	☐ Feeling tearful	☐ Self esteem problem	☐ Easily irritated
☐ Trouble concentrating	☐ Perfectionism	☐ Change in sleeping habits	☐ Feeling guilty
☐ Memory problems	☐ Lack of energy	☐ Obsessions or compulsions	☐ Feeling nervous
☐ Change in eating habits	☐ Weight changes	☐ Sudden feeling of panic	☐ Feeling fearful
☐ Feeling of extreme happiness	☐ Change in sexual interest or function	☐ Physical complaints of pain	☐ Muscle tension
☐ Trouble performing your job your job	☐ Problems w/ anger	☐ Problems getting along with friends or family	☐ Acting violently

☐ Thoughts of hurting yourself or others ☐ Thoughts of killing yourself or others

HAVE YOU EVER BEEN IN COUNSELING BEFORE? ☐ Yes ☐ No

If so, who? ______________________________ When? ______________________________

Explain what happened? ____

HAVE YOU EVER BEEN HOSPITALIZED FOR A MENTAL/EMOTIONAL/SUBSTANCE ABUSE CONDITION?
☐ Yes ☐ No If yes, Where ______________________________ When __________

ANY KNOWN OR SUSPECTED ABUSE? ☐ Yes ☐ No If yes, explain______________________

MEDICAL INFORMATION:
Have you seen the doctor within the past year? ☐ Yes ☐ No If yes, who? ______________

Why did you see the doctor? ____

List any medications you are taking with dosage: ______________________________

List any allergies you may have: ____

SUBSTANCE USE HISTORY

Do you use/have you used tobacco (any form)?	☐ No	☐ Current	☐ Past	How much? ________
Do you use/have you used alcohol?	☐ No	☐ Current	☐ Past	How much? ________
Do you use/have you used caffeine (any form, including cola drinks)?	☐ No	☐ Current	☐ Past	How much? ________
Do you use/have you used recreational drugs?	☐ No	☐ Current	☐ Past	How much? ________