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TODAY'S DATE_____

Patient Information:

Name_____DOB & Age_____ Male Female

OK TO CALL/TEXT?___ Ph. # _____EMAIL:_____

Address_____City, State, Zip_____

Employer_____Occupation_____Full or Part

Length of Employment_____Work Address_____Phone_____

If patient is a minor, please state School_____Grade_____

Marital Status_____Previous Marriages?_____ # Of Children living with you?_____

Their Names & Ages_____

Recent Health Problems_____Rx Taking_____

Primary Dr._____Location_____

Ever had any problem with Alcohol or Drugs? If yes, when:_____

Ever considered or attempted Suicide?_____ Had Previous Counseling?_____

General Reason For This Appointment_____

Date of First Symptom_____Referred to me by anyone?_____

SPOUSE (If Married) OR RESPONSIBLE PARTY (If different from above)

Name_____Relationship to patient_____

Your Date of Birth_____Address_____

Primary Phone # _____

(OVER)

Please circle any of the following items which apply to you:

nervousness
fears or anxiety
divorce
sleep problems
stress
concentration/attention
tension
bowel/stomach troubles
loneliness
faintness
sadness or tears
spots/stars in front of eyes
self-destructive feelings/actions
suicidal thoughts
profuse perspiration
extreme moodiness
legal problems
hallucinations
difficulties with friends
shyness
sexual problems
financial problems
fatigue/loss of energy

anger/temper
nightmares
appetite-loss or increase
pain
drugs
marital problems
decision-making
inferiority feelings
dizziness
feeling out of control
backaches
suicide attempt
extremity numbness/tingling
feeling like you're falling apart
mood swings
depression
separation
work-related problems
health problems
memory loss or changes
headaches
alcohol
career choices

school/education problems
being a parent
ringing in ears
frightening memories/flashba
relationship problems
rapid heartbeat
troubling thoughts
physical/sexual abuse