Client Name:_____ Date Completed: _____
Client Age:_____

Reason for Seeking Treatment: _____

_____

_____

_____

Rate Intensity of Presenting Problem: 1 2 3 4 5 6 7 8 9 10

During the past TWO WEEKS, how much or how often have you been bothered by the following problems?

	None	**Slight** Rare	**Mild** Several Days	**Moderate** More than half the Days	**Severe** Nearly every Day
Little interest or pleasure in doing things?	0	1	2	3	4
Feeling down, depressed, or hopeless?	0	1	2	3	4
Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4
Sleeping less than usual, but still having a lot of energy?	0	1	2	3	4
Starting lots more projects than usual or Doing more risky things than usual?	0	1	2	3	4
Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4
Feeling panic or being frightened?	0	1	2	3	4
Avoiding situations that make you anxious?	0	1	2	3	4
Unexplained aches and pains (e.g., head, back, joints, abdomen, legs?)	0	1	2	3	4
Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4
Thoughts of actually hurting yourself?	0	1	2	3	4
Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4

Client Name: _____

Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4
Problems with sleep that affected your sleep quality overall?	0	1	2	3	4
Problems with memory (e.g., learning new information) or with location (e.g,. finding your way home)?	0	1	2	3	4
Unpleasant thoughts, urges, or images that repeatedly entered your mind?	0	1	2	3	4
Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4
Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4
Not knowing who you really are or what you want out of life?	0	1	2	3	4
Not feeling close to other people or enjoying your relationship with others?	0	1	2	3	4
Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4
Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4

Prior Therapy: ___ ___ With Whom: _____
_____
Dates: _____
Diagnoses: _____

Psychiatric Hospitalization: ___ ___ Where? _____
When? _____
How Long? _____

Current Medications: Name	Dosage	Date Begun	Prescribed By
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medical Conditions:	Yes	No	Explanation:
Hepatitis:	___	___	_____
Thyroid Disease:	___	___	_____
HIV/AIDS:	___	___	_____
Diabetes:	___	___	_____
Heart Disease:	___	___	_____
Gastrointestinal:	___	___	_____
Seizures:	___	___	_____
Migraines:	___	___	_____
Cancer:	___	___	_____
Drug Allergies:	___	___	List: _____
			_____
Other Medical Conditions:	___	___	_____
Hospitalizations:	___	___	Reason: _____
			_____
			When? _____

Family History:

Have members of your family ever had any of the following problems? Include parents, grandparents, uncles, aunts, brothers, sisters, and children.

Depression:	___	___	_____
Anxiety:	___	___	_____
Manic Depression/Bipolar	___	___	_____
Suicide Attempt:	___	___	_____
Completed Suicide:	___	___	_____
Learning Disability:	___	___	_____
Schizophrenia:	___	___	_____
Alcohol Abuse:	___	___	_____
Drug Abuse:	___	___	_____