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

	Yes	No	Explanation:
Normal Energy Level:	___	___	_____
Sleep Disturbance:	___	___	_____
Appetite Changes:	___	___	_____
Exercise:	___	___	_____
Anger/Hostility:	___	___	_____
Poor Concentration:	___	___	_____
Irritability/Agitation:	___	___	_____
Mood Swings:	___	___	_____
Obsessive Thoughts:	___	___	_____
Compulsions:	___	___	_____
Anxiety/Tension:	___	___	_____
Memory Problems:	___	___	_____
Fearfulness:	___	___	_____
Hallucinations:	___	___	_____
Paranoid Thoughts:	___	___	_____
Depressed Mood:	___	___	_____
Hopelessness:	___	___	_____
Suicidal Thoughts:	___	___	_____
Homicidal Thoughts:	___	___	_____
Family/Friend Support	___	___	_____
Social Isolation:	___	___	_____
Violent Behavior:	___	___	_____
Arrests:	___	___	_____
Legal Issues:	___	___	_____
Prior Therapy:	___	___	With Whom: _____
			_____
			Dates: _____
			Diagnoses: _____
Psychiatric Hospitalization:	___	___	Where? _____
			When? _____
			How Long? _____
Have you ever been on Disability:	___	___	_____

Highest Education You've Attained: _____
Religious/Faith Orientation: _____

Client Name: _____

Caffeine Use	___	___	How Much? _____
Cigarette Smoker	___	___	How Much? _____
Alcohol	___	___	Frequency? _____
			Amount? _____
			Last Used? _____
Drug Use	___	___	Type (s): _____
			Amount? _____
			Last Used? _____

Current Mediations:	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:	___	___	_____