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Overall health (circle one):

Excellent Good Fair Poor Other

Family History

	Name	If Living		If Deceased	
		Age	Health	Age & Year	Cause
Father					
Mother					
Brother(s)					
Sisters (s)					
Spouse					
Son(s)					
Daughter(s)					
Other: (Steps) & relationships					

Medical History

Are you taking any medicines, drugs, over-the-counter medications or vitamins? Yes _____ No _____

If so list by name & dosage. Be SURE to list any medication associated with thyroid, heart, blood pressure, pain, sleep, nervousness, depression, epilepsy, birth control, weight reduction, or hormones: _____



Medical Hospitalizations:

Year	Illness:	Doctor:

Surgical Hospitalizations:

Year	Illness:	Doctor:

Other serious illnesses or injuries: _____

Previous psychiatric and/or counseling treatment (practitioner, year, type of treatment, medication, & purpose): _____

Current Stressor(s): _____

Reasons for seeking counseling now (major problem): _____

How have you addressed these concerns already? _____

What would you like to accomplish through counseling: _____

More specific information you would like for me to know: _____



Have you experienced any of the following in the last 6 months:

Symptom	Yes	No	Symptom	Yes	No
Depressed mood?			Sleep disturbance?		
Loss of interest?			Panic attacks?		
Loss of pleasure?			Excessive muscle tension?		
Excessive fatigue?			Excessive nervousness?		
Loss of appetite?			Difficulty breathing/smothering?		
Increase in appetite?			Obsessions?		
Thoughts of self-harm?			Feeling very slowed down?		
Thoughts of harming others?			Dizziness/Faintness?		
Trouble concentrating?			Tremors?		
Weight gain?			Sweating?		
Weight loss?			Tingling/Numbness?		
Agitation?			Flushes/Chills?		
Feelings of unreality?			Fear of losing control?		
Inappropriate elation?			Hallucinations (seeing or hearing things)?		
Inappropriate irritability?			Suspiciousness of several people?		
Grandiose notions?			Overly rapid/Skipping heartbeat?		
Increased pressured speech?			Difficulty remembering/Mind going blank?		
Disconnected, racing thoughts?			Unwanted recurrent persistent thoughts?		
Markedly increased energy?			Repetitive behavior or mental acts that you feel driven to perform?		
Distractibility?			Behaviors or thoughts aimed at warding off some dreaded event?		
Impulse control problem?			Wide mood swings?		
Low self-esteem?			Social withdrawal?		
Nervous habits?					
Confusion?					

Explanation of symptoms (if necessary): _____

