Clinical Information

Client Name _____ Date _____

Person completing this form_____ Relationship to Client_____

Previous mental health treatment? ___No ___ Yes

Therapist Name, Dates and Outcome:_____

Primary Care Physician _____Date of last physical exam:_____

MEDICATION	DOSAGE	PRESCRIBED BY

Client statement of presenting problem:_____

_____

_____

Family statement of presenting problem: _____

_____

_____

Please check all symptoms:

____Fatigue
____Sleep Disturbance
____ Loss of interest in daily activities
____Decreased Concentration
____Memory Loss
____Feelings of worthlessness
____Loss of sexual desire
____Panic/Anxiety
____Lying
Other_____
_____

____Paranoia
____Obsessive Behavior
____Irritability
____Rebellious/Defiant
____Mood Swings
____Stealing
____Isolation
____Anger
____Flashbacks

____Easily agitated
____Extreme Sadness
____Homicidal
____Violent
____Excessive Guilt
____Hallucinations/Delusions
____Suicidal
____Change in appearance
____Alcohol Use
____Alcohol Abuse
____Drug Use
____Drug Abuse

Who suggested you come here today? (Check all that are true for you)

___My own decision ___Family or partner ___Employer ___Doctor or other health professional