PATIENT DATA FORM

Date: _____ Date of Birth: _____

Name: _____ Age: _____ SS #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: home _____ work _____

In case of an emergency, contact: _____

Phone: _____ Relationship: _____

Are you employed? ☐ Yes ☐ No Where: _____

How long? _____ Are you satisfied? ☐ Yes ☐ No

Marital Status: ☐ married ☐ single ☐ divorced ☐ widowed ☐ living with partner

☐ Other _____

With whom do you live? ☐ spouse ☐ partner ☐ roommate ☐ alone ☐ parents

☐ other _____

Number of children at home: _____ ages/sex: _____

Family doctor: _____ Phone: _____

List any past medical problems (including serious surgeries, hospitalizations and head injuries). Please include year of occurrence: _____

_____

_____

List any current ongoing medical problems: _____

_____

List all medications you are currently on: _____

List any allergies to medications: _____

Have you ever received counseling for any reason? ☐ Yes ☐ No

When: _____ Where: _____

_____ _____

_____ _____

Have you ever been hospitalized for a psychiatric reason? ☐ Yes ☐ No

When: _____ Where: _____

PATIENT DATA FORM

Have you ever received treatment for drugs or alcohol? ☐ Yes ☐ No

When: _____ Where: _____

_____ _____

_____ _____

Have you attended any self-help groups like AA, CODA, etc.: ☐ Yes ☐ No

Type/Last attended _____

Please check which of the following applies

Why are you here?

- ☐ I'm in crisis
- ☐ It would help me to talk to someone
- ☐ I would like some counseling for someone close to me
- ☐ I need medication to help the way I feel
- ☐ It's not me who has the problem, I'm here because someone else sent me
- ☐ I need a question answered
- ☐ I need advice on a specific problem
- ☐ I need some testing
- ☐ I need a referral to be sent elsewhere
- ☐ Other (please specify) _____

_____

I think I can be helped with my problem in:

☐ 1 session ☐ 2-5 sessions ☐ 6-10 sessions ☐ more than 10 sessions

Who suggested that you come?

- ☐ Self
- ☐ Work
- ☐ Doctor
- ☐ Spouse

Other _____

PATIENT DATA FORM

PROBLEM INVENTORY

I am **currently** having the following problems (please check all that apply)

- ☐ Problems with my memory
- ☐ Knowing where or who I am
- ☐ Getting lost or confused

- ☐ People following me, out to hurt me, or talking about me
- ☐ People reading my thoughts
- ☐ Hearing voices
- ☐ Thoughts being put into my head, controlling me, making me do things
- ☐ Special messages to me from TV or radio

- ☐ Feeling guilty about past misdeeds
- ☐ Feeling that I am no good
- ☐ Feeling the need to get more sleep
- ☐ Losing pleasure in my daily activities
- ☐ Often feeling restless or irritable
- ☐ Thinking about dying or killing myself
- ☐ Trouble keeping my mind on a task
- ☐ Preoccupied with sexual thoughts or urges
- ☐ Needing less sleep than usual
- ☐ Spending sprees
- ☐ Trouble making myself slow down or talk less
- ☐ Feeling helpless about my eating habits
- ☐ Fear of crowds or public places
- ☐ Specific fear of a thing or place
- ☐ Heart palpitations
- ☐ Chest pains or discomfort
- ☐ Feeling dizzy or unsteady
- ☐ Feeling things that aren't there
- ☐ Tingling in hands or feet
- ☐ Hot or cold flashes
- ☐ Can't get my breath
- ☐ Feeling trembly or shaky
- ☐ Fears of dying or going crazy
- ☐ Feeling the urge to avoid certain places or objects
- ☐ Other _____

- ☐ Feeling the urge to do something unnecessary
- ☐ Checking, handwashing, hairpulling
- ☐ Feeling emotionally "numb"
- ☐ Recurring nightmares
- ☐ Frequently feeling startled
- ☐ Being troubled by painful memories

- ☐ Parts of my body not functioning well
- ☐ Feeling aches and pains all over my body
- ☐ Often feeling sickly
- ☐ Fear of having or getting a disease

- ☐ Having trouble remembering my past
- ☐ Finding things I don't remember having
- ☐ Feeling that I've lost time

- ☐ Urges to harm myself or others
- ☐ Urges to set fires
- ☐ Difficulty controlling my temper
- ☐ Taking laxatives to control my weight
- ☐ Vomiting to control my calorie intake
- ☐ Exercising frequently and vigorously
- ☐ Fasting in order to control my weight
- ☐ Extreme changes in my weight
- ☐ Attacks of fearfulness where I feel I need to run
- ☐ Marital relationship problems
- ☐ Physical abuse
- ☐ Problems on the job
- ☐ Losing someone or something close to me (person, job, pet, moving, etc.)
- ☐ Problems with my children
- ☐ Sexual abuse
- ☐ Current problems from past sexual abuse
- ☐ Alcohol abuse
- ☐ Drug abuse
- ☐ Feeling troubled by repetitive thoughts

_____