

STRENGTHS & ISSUES CONTINUED

What is going well in your life?

Hobbies & Interests?

How are your family relationships (current family and family of origin)?

Do you have any health issues or injuries?

What are your goals for this visit?

Is there any other information that may be helpful (for example, issues of diversity, spirituality or significant recent events)?

Check any of the symptoms that you are having:			
Depression		Feeling hopeless	
Extreme sadness		Feeling tearful	
Trouble concentrating		Change in sleeping habits	
Memory problems		Lack of energy	
Change in eating habits		Weight changes	
Feeling of extreme happiness		Change in sexual interest or function	
Trouble performing your job		Problems getting along with friends or family	
Lack of enjoyment of usual activities		Feeling stressed	
Self-esteem problems		Easily irritated	
Perfectionism		Feeling guilty	

Obsessions or compulsions		Feeling nervous	
Feeling fearful		Sudden feelings of panic	
Physical complaints of pain		Muscle tension	
Problems with anger		Acting violently	
Thoughts of hurting yourself or others		Thoughts of killing yourself or others	

HAVE YOU EVER BEEN IN COUNSELING BEFORE? Yes [] No []

If you have been in counseling before, please describe it below. Start with the most recent time first.

A Date(s):	
Provider Name:	
Explain what happened:	

B. Date(s):	
Provider Name:	
Explain what happened:	

C. Date(s):	
Provider Name:	
Explain what happened:	

MEDICAL INFORMATION

Have you seen a doctor within the last year?		Yes [<input type="checkbox"/>]	No [<input type="checkbox"/>]
Why have you seen a doctor?			
Who is your doctor?			
Location:		Phone:	
Are you taking any medications, prescription or over-the-counter?		Yes [<input type="checkbox"/>]	No [<input type="checkbox"/>]
Please describe:			
Medications	Dosages		
1.			
2.			
3.			
4.			

SUBSTANCE USE HISTORY

Do you use/ have you used tobacco (any form)?	Current [<input type="checkbox"/>]	Past [<input type="checkbox"/>]	No [<input type="checkbox"/>]
Do you use/ have you used alcohol?	Current [<input type="checkbox"/>]	Past [<input type="checkbox"/>]	No [<input type="checkbox"/>]
Do you use/ have you used caffeine (any form, including cola drinks)?	Current [<input type="checkbox"/>]	Past [<input type="checkbox"/>]	No [<input type="checkbox"/>]
Do you use/ have you used other mind-altering substances (drugs)? If yes, please describe:	Current [<input type="checkbox"/>]	Past [<input type="checkbox"/>]	No [<input type="checkbox"/>]
1.	Current [<input type="checkbox"/>]	Past [<input type="checkbox"/>]	
2.	Current [<input type="checkbox"/>]	Past [<input type="checkbox"/>]	
3.	Current [<input type="checkbox"/>]	Past [<input type="checkbox"/>]	
4.	Current [<input type="checkbox"/>]	Past [<input type="checkbox"/>]	

**IF THERE IS OTHER INFORMATION THAT YOU THINK IS IMPORTANT,
 PLEASE ATTACH ADDITIONAL SHEETS**