

Name: _____ DOB: _____ Date: _____

HOW DID YOU FIND OUT ABOUT US?

Referral Source: _____ Agency: _____
Telephone: _____
Address: _____

WHAT PROMPTED YOU TO CONTACT US FOR HELP?

CURRENT SYMPTOMS AND PROBLEMS (Circle any problems you have experienced in the past month.)

- | | | | |
|-----------------------------|-----------------------------|-----------------------------|---------------------------|
| Depression | Unhappy with your situation | Short attention span | Hallucinations |
| Grief/loss | Pessimism about the future | Memory problems | Paranoid thoughts |
| Anxiety | Traumatic memories | Compulsive behaviors | Other unusual thoughts |
| Panic attacks | Nightmares | Compulsive overeating | Self-destructive behavior |
| Fears/phobias | Sleep disturbance | Anorexia | Suicidal urges |
| Obsessional worry | Appetite changes | Bulimia | Aggressive urges |
| Feeling helpless or trapped | Fatigue/energy problems | Alcohol abuse or dependence | Other: |
| Unhappy with your self | Inability concentrating | Drug abuse or dependence | |

HABITS & SUBSTANCE USE

SUBSTANCE	AMOUNT USED
Tobacco products:	_____
Alcohol:	_____
Street drugs:	_____
Other:	_____

PSYCHIATRIC TREATMENT HISTORY

PSYCHIATRIST/THERAPIST/HOSPITAL	DATES
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____