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Overall health (circle one):
Excellent Good Fair Poor Other

**Family History**

| | | If Living | | If Deceased | |
|---|---|---|---|---|---|
| | Name | 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 followng 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? | | | | | |
| Impulse control problem? | | | Behaviors or thoughts aimed at warding off some dreaded event? | | |
| Low self-esteem? | | | | | |
| Nervous habits? | | | Wide mood swings? | | |
| Confusion? | | | Social withdrawal? | | |

**Explanation of symptoms** (if necessary):_____

_____

_____

_____