

Client History:

Presenting Problem/Reason for attending program:

These behaviors are most problematic at (check all that apply):

Home School Social Situations Work Other: _____

➤ **Please check behaviors and symptoms that occur more often than you would like:**

- | | | |
|---|---|---|
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Depression | <input type="checkbox"/> Aggression |
| <input type="checkbox"/> Drug dependence | <input type="checkbox"/> Social impairments | <input type="checkbox"/> Alcohol dependence |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Avoiding people | <input type="checkbox"/> Cyber Addiction |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Appetite disturbance | <input type="checkbox"/> Sleep disturbance/nightmares |
| <input type="checkbox"/> Elevated mood | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Hopelessness |
| <input type="checkbox"/> Helplessness | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Reoccurring thoughts | <input type="checkbox"/> Phobias/Fears | <input type="checkbox"/> Sexual addiction |
| <input type="checkbox"/> Sexual difficulties | <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Disorganized thoughts |
| <input type="checkbox"/> Concentration problems | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Frequent illnesses |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Worrying | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |

Please explain:

➤ **My *most* concerning behavior(s) is/are:**

➤ **The top 3 expectations I have for this program:**

1) _____
2) _____
3) _____

➤ **Current Treatment Provider's:**

Psychiatrist: _____

Psychotherapist: _____

Diagnosis: _____

Medications: *Current:* _____

Past: _____

Case Manager: _____

➤ **Educational/ Work Information:**

Years of Education: _____ Currently Enrolled: _____ Yes _____ No

_____ High School Graduate/GED

_____ Vocational : Number of years _____ Graduated ___ Yes ___ No Major: _____

_____ College : Number of years _____ Graduated ___ Yes ___ No Major: _____

_____ Graduate School: Number of years Graduated ___ Yes ___ No Major _____

Occupation: _____

How many hours a week do you work? _____

➤ **Past Psychiatric History:**

Reason for stopping treatment with previous therapist: _____

Psychiatric hospitalizations: Yes No

If Yes, last hospitalization at: _____ Date: _____

Total Number of psychiatric hospitalizations: _____

Reason for admission:

➤ **Legal History:**

Current legal issues: Yes No Past legal issues: Yes No

€ Probation € Parole € Restraining Order Other _____

If Yes, please explain:

➤ **Abuse History:**

Have you ever been a victim of abuse or neglect ___ Yes ___ No

If yes, what was the nature of the abuse? (Please circle all that apply)

Physical Emotional Neglect Sexual Other

(If Applicable) Are you struggling with your marital relationship or parenting? ___ Yes ___ No
If yes, Please describe: _____

➤ **Alcohol and substance abuse history and treatment:**

Family History:

Review the list below- if any relative has one of these disorders, check the disorder and describe their relation to you (such as “maternal uncle”) and their treatment history (if applicable).

___ Depression _____

___ Anxiety _____

___ Bipolar (Manic Depressive) _____

___ Schizophrenia _____

___ Alcohol/Drug problems _____

___ Learning Disabilities _____

___ Autism/Aspergers/Pervasive Developmental Disorder _____

___ ”Nervous Breakdown” _____

___ Psychiatric Hospitalizations _____

___ Suicide (or attempts) _____

___ Panic Disorder _____

___ PTSD (Post Traumatic Stress Disorder) _____

___ OCD (Obsessive Compulsive Disorder) _____

___ Thyroid _____

