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.	