PATIENT BACKGROUND INFORMATION

YOUR NAME: _____

Does anyone else live with you in your home currently? Please list.

Name	Relationship	Age	How long?

Please list any known psychiatric or mental health and/or substance abuse concerns/problems in your family history (for example, depression—maternal grandmother; bipolar—dad; anxiety—both parents)? Please provide me with this basic history information below:

☐ Check here if there is no known family history of mental health and/or substance abuse concerns/problems.

Please list any past or current significant health/medical issues, illnesses, or treatments?

☐ Check here if there is no known history of significant health/medical issues, illnesses, or treatments.

Please list any medications you take currently.

☐ Check here if you do not presently take any medications.

Name of Medication?	**Dosage?**	**How Long?**	**Reason?**
(example: Zyrtec	50 mg.	2 years	seasonal allergies)

Very Important: Insurance companies will only reimburse for your care if there is a medical necessity. Medical necessity is determined in part by the severity of reported symptoms and the impact these symptoms have on your ability to function effectively. So please take this checklist very seriously and fill out out carefully.

Have you experienced any of the following recently compared to what is normal for you?
(Check if the symptom applies, provide an estimate of how long you've been experiencing the symptom, and rate the level of severity/difficulty you're experiencing with regard to it limiting your ability to function more effectively (personally, socially, academically, at work) **0=no difficulty; 1=a little difficulty; 2=moderate difficulty; 3=quite a bit of difficulty; 4=extreme difficulty**)

___Appetite/Weight Changes Duration of symptom? _____ Severity? _____

___Not eating, binge eating or purging Duration of symptom? _____ Severity? _____

___General Eating/Body Image Concerns Duration of symptom? _____ Severity? _____

___Memory Problems Duration of symptom? _____ Severity? _____

___Concentration Problems Duration of symptom? _____ Severity? _____

___Crying Episodes Duration of symptom? _____ Severity? _____

___Increased Irritability Duration of symptom? _____ Severity? _____

___Depressed Mood (feeling down/sad?) Duration of symptom? _____ Severity? _____

___Social Withdrawal Duration of symptom? _____ Severity? _____

___Changes in Energy Level Duration of symptom? _____ Severity? _____

___Manic Episodes Duration of symptom? _____ Severity? _____

___Panic Attacks Duration of symptom? _____ Severity? _____

___Unusual Behaviors/Rituals/Habits Duration of symptom? _____ Severity? _____

___Obsessive Thoughts Duration of symptom? _____ Severity? _____

___Anxiety/Worry Duration of symptom? _____ Severity? _____

___Cutting/Self-Injurious Behavior Duration of symptom? _____ Severity? _____

___Alcohol/Drug Use/Abuse Duration of symptom? _____ Severity? _____

___Thoughts of Harming Self Duration of symptom? _____ Severity? _____

___Past Attempts at Self-Harm/Suicide Duration of symptom? _____ Severity? _____

___Recent Losses Duration of symptom? _____ Severity? _____

___Feeling excessively guilty Duration of symptom? _____ Severity? _____

___Recurrent Thoughts of Death Duration of symptom? _____ Severity? _____

___Decreased Interest or Pleasure in Activities Duration of symptom? _____ Severity? _____

___Sleep Problems (Can't Sleep, Oversleep, Interrupted Sleep) Duration? _____ Severity? _____

___Decreased need for sleep (feeling rested w/ little to no sleep) Duration? _____ Severity? ____

___Feelings of Worthlessness Duration of symptom? _____ Severity? _____

___Difficulty Making Decisions Duration of symptom? _____ Severity? _____

___Feeling Restless Duration of symptom? _____ Severity? _____

___Feeling Slowed Down Duration of symptom? _____ Severity? _____

___Racing Thoughts Duration of symptom? _____ Severity? _____

___Distractibility Duration of symptom? _____ Severity? _____

___More Talkative/Pressure to Keep Talking Duration of symptom? _____ Severity? _____

Any other symptoms that are bothering you that I have not asked about here?

_____

_____

_____

Please list any prior mental health treatment and/or hospitalizations?
(please include approximate dates, location, provider, and reason)

☐ Check here if you have no prior mental health treatment history

_____

_____

_____

_____

Please indicate highest educational level attained:

☐ some high school courswork
☐ have a high school degree
☐ GED
☐ have some college coursework
☐ have a college degree
☐ some graduate work (e.g., Master's program, law program, etc).
☐ have an advanced graduate degree (e.g., M.A., Ph.D., J.D., M.D.)

What are your primary goals of therapy?

1.

2.

3.