

Primary Care Physician: _____ Phone: _____

Address: _____

Current Health Problems: _____

Medications Prescribed: _____ Date of Last Visit: _____

Counseling History:

Previous Psychiatric or Psychological Services: ____ Yes ____ No

Treatment Provider: _____ Phone: _____

Address: _____

Reason for seeking care: _____

Treatment outcome: _____

Treatment Provider: _____ Phone: _____

Address: _____

Reason for seeking care: _____

Treatment outcome: _____

Please circle any of the following problems that pertain to you:

- | | | |
|----------------|----------------------|-------------------|
| Nervousness | Depression | Fears |
| Shyness | Sexual Problems | Suicidal Thoughts |
| Separation | Divorce | Finances |
| Drug Use | Alcohol Use | Friends |
| Anger | Self-Control | Unhappiness |
| Sleep | Stress | Work |
| Relaxation | Headaches | Tiredness |
| Legal Matters | Memory | Ambition |
| Energy | Insomnia | Making Decisions |
| Loneliness | Inferiority Feelings | Insomnia |
| Education | Career Choices | Health Problems |
| Temper | Nightmares | Marriage |
| Children | Appetite | Stomach Trouble |
| Bowel Troubles | Being a Parent | My Thoughts |

List the members of your family and all others in your home:

Name	Age/Birth Date	Relationship
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Please add any information that you think may be useful to us: _____
