



Name: _____ Date: _____

What concern(s) brings you to Counseling?

Three horizontal lines for writing concerns.

What changes do you want to see as a result of coming to Counseling?

Three horizontal lines for writing desired changes.

Client's Medical History

Currently under a doctor's care: ____ Yes ____ No

Doctor(s) involved in your care: _____

Health problems (include allergies): _____

Medication currently used: None

Table with 4 columns: Medication, Dosage, Doctor Prescribing, Why Prescribed. Includes three rows of horizontal lines for data entry.

Past Hospitalizations - Medical, Psychiatric, Chemical Dependency: None

Table with 3 columns: Date (s), Reason (s), Hospital. Includes three rows of horizontal lines for data entry.

Previous Counseling, EAP or Chemical Dependency Services: None

Table with 4 columns: Facility/Counselor Name, Date (s), Reason (s), Helpful?. Includes three rows of horizontal lines for data entry.

Symptom Checklist

Please complete for each person attending the first appointment

Client's Name: _____ Date: _____

Person Completing Form: _____

Please check how often these symptoms occurred *in the last 6 months*. If you are a parent completing this form for your child/adolescent, please provide your child's/adolescent's symptoms *in the last six months*.

| SYMPTOM | Never or rarely | A few times a month | Nearly every day | SYMPTOM | Never or rarely | A few times a month | Nearly every day |
|--------------------------|-----------------|---------------------|------------------|-----------------------------------|-----------------|---------------------|------------------|
| Guilt Feelings | | | | Hopeless about future | | | |
| Worrying | | | | Thinking about death | | | |
| Too much energy | | | | Thinking about suicide | | | |
| Aggressive | | | | Problems with family members | | | |
| Uncontrolled temper | | | | Brooding about the past | | | |
| Afraid of work/school | | | | Crying excessively | | | |
| Afraid of leaving house | | | | Feeling down or sad | | | |
| Sleep walking | | | | Nightmares | | | |
| Problems falling asleep | | | | Feeling anxious | | | |
| Problems staying asleep | | | | Feeling panicky | | | |
| Memory loss | | | | Problems with anger | | | |
| Trouble making decisions | | | | Feeling jealous | | | |
| Feeling alone | | | | Feeling impatient | | | |
| Difficulty concentrating | | | | No confidence in self | | | |
| Sudden mood changes | | | | Shortness of breath | | | |
| Restlessness | | | | Fast heart beat | | | |
| Easily Distracted | | | | Chest pains | | | |
| Problems getting along | | | | Feelings of unreality | | | |
| Feeling worthless | | | | Lying | | | |
| Overly tired | | | | Problems at home | | | |
| Poor or no appetite | | | | Alcohol use | | | |
| Over eating | | | | Drug use | | | |
| Bingeing | | | | Blackouts | | | |
| Food preoccupation | | | | Stomach Problems | | | |
| Vomiting | | | | Uncontrolled thoughts | | | |
| Sleeping too much | | | | Uncontrolled behavior | | | |
| Hearing voices | | | | Physical abuse of self or others | | | |
| Problems at work/school | | | | Emotional abuse of self or others | | | |
| Stealing | | | | Other: | | | |