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Self-Assessment

What influenced you to schedule this appointment? _____

Who referred you to our practice? (e.g. Physician, psychiatrist, friend, Psychology Today, Google, etc.)

What would you like to see accomplished in therapy? _____

Previous outpatient therapy? Y N
What was accomplished? _____

Previous hospitalization? Y N
When/For What? _____

CHIEF COMPLAINT (Check all that apply to you):

__ Depression
__ Low energy
__ Low self-esteem
__ Poor concentration
__ Hopelessness
__ Worthlessness
__ Guilt
__ Sleep disturbance (more/less)
__ Appetite disturbance (more/less)
__ Thoughts of hurting yourself
__ Thoughts of hurting someone else
__ Isolation/social withdrawal
__ Sadness/loss
__ Stress
__ Anxiety/panic
__ Heart pounding/racing
__ Chest pain
__ Trembling/shaking
__ Sweating
__ Chills/hot flashes
__ Tingling/numbness
__ Fear of dying
__ Fear of going crazy
__ Nausea
__ Phobias
__ Obsessions/compulsive behaviors
__ Thoughts racing
__ Can't hold onto an idea
__ Easily agitated
__ Excessive behaviors (spending, gambling)
__ Delusions/hallucinations
__ Not thinking clearly/confusion
__ Feeling that things around you are not real
__ Lose track of time
__ Unpleasant thoughts won't go away
__ Anger/frustration
__ Easily agitated/annoyed
__ Defies rules
__ Blames others
__ Argues
__ Excessive use of drugs and/or alcohol
__ Excessive use of prescription medications
__ Blackouts
__ Physical abuse issues
__ Sexual abuse issues
__ Spousal abuse issues
__ Other problems/symptoms:
_____
_____
_____
_____
_____