

# Self Report Form

## Client Information

Name (First, M.I., Last):		
Street:		
City:	State:	Zip Code:
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )
Social Security #:		Email:
Date of Birth:		Gender: M F
Marital Status: Single Married Widowed Divorced Separated Partnered Minor		
Employment Status: Full-time Part-time Retired Non-employed		If Student: Full-time Part-time
Employer:		
School (if student):		
Occupation:		
Emergency Contact - Name:	Phone:	Relation to Client:
Whom may we thank for referring you?		

The following questions will help with serving you. Please read and answer each question carefully.

## Mental Health History

Why are you seeking treatment?

- Depression       Anxiety       Substance Abuse  
 Family Issues       Relationships       Employment Issues  
 Other (please describe)

Have you ever been hospitalized for psychiatric issues or chemical dependence?       Yes       No

If yes, please list below the diagnosis, when, where, and by whom.

Have you ever been treated by a psychiatrist, therapist, EAP, or other clinician?       Yes       No

If yes, please list below the diagnosis, when, where, and by whom.

If applicable, please list below any traumatic or extremely upsetting events that might have occurred to you.

**Are you experiencing:**

<u>Depression:</u>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<u>Loss of interest in activities:</u>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<u>Loss or increase in appetite:</u>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<u>Significant weight loss or gain:</u>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<u>Increase or decrease in sleep:</u>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<u>Increase or decrease in energy level:</u>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<u>Feelings of worthlessness or guilt:</u>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<u>Problems in concentration or decision making:</u>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<u>Thoughts about death, suicide, or self-harm:</u>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<u>Anxiety:</u>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<u>Panic or anxiety attacks:</u>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<u>Fears:</u>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<u>Nightmares:</u>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<u>Eating in excess:</u>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<u>Concerns about body image:</u>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<u>Persistent unpleasant thoughts:</u>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<u>Times when you engage in repetitive behaviors:</u>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<u>Worries about physical health, finances, other:</u>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Have you ever experienced any of the following:**

<u>Periods of at least 4 days when you were so happy or excited you got into trouble or others became worried about you?</u>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<u>Periods of at least 4 days of irritability or temper problems?</u>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<u>Racing thoughts or an inability to keep up with your thoughts?</u>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<u>Thoughts that others are "out to get you?"</u>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<u>Hallucinations (i.e. seeing, hearing, or feeling, something others cannot?)</u>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<u>Memory problems?</u>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Substance Use/Abuse History**

How many times during the month do you consume alcohol?

How much do you drink each time?

Do you use any illegal drugs (Marijuana, Cocaine, Amphetamines, Heroin, other)?  Yes  No  
If yes, please list below.

Have you used any illegal drugs in the past?  Yes  No  
If yes, please list below, and time of last use.

Have you ever abused prescription medications or over-the-counter medications such as pain medications, narcotics, anxiety medications, tranquilizers, or sleeping medications?  Yes  No

If yes, please describe below:

Have you ever participated in NA/AA or other self-help programs?  Yes  No

How many caffeine products (soda, coffee, energy drinks) do you consume each day?

Do you use tobacco products?  Yes  No

If yes, please describe below what you use and how much.

### **Family History**

Is there any family history of any of the following:

high blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

Is there any family history of mental conditions or chemical dependence such as:

depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	attention deficit	<input type="checkbox"/> Yes	<input type="checkbox"/> No
bipolar disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	anxiety disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
schizophrenia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	alcoholism	<input type="checkbox"/> Yes	<input type="checkbox"/> No
mental retardations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	drug addiction	<input type="checkbox"/> Yes	<input type="checkbox"/> No
learning problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	suicides/attempts	<input type="checkbox"/> Yes	<input type="checkbox"/> No
other (please describe)	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

### **Family History**

Please list any current medical problems and the name of your treating physician:

Please list all current psychiatric medications:

<u>Medication</u>	<u>Dosage/Size</u>	<u>How long</u>	<u>Reason/Effect</u>	<u>Prescribing Clinician</u>
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Please list all other current medications including prescription and over the counter:

<u>Medication</u>	<u>Dosage/Size</u>	<u>How long</u>	<u>Reason/Effect</u>	<u>Prescribing Clinician</u>
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Please list all past psychiatric medications:

<u>Medication</u>	<u>Dosage/Size</u>	<u>How long</u>	<u>Reason/Effect</u>	<u>Prescribing Clinician</u>
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Are you allergic to any medications?  Yes  No  
If yes, please list below:

Have you ever experienced head trauma with loss of consciousness?  Yes  No

Have you ever experienced seizures?  Yes  No

If you are a woman, are you pregnant or plan to be?  Yes  No  Unsure

Have you ever been hospitalized for major surgeries or illness?  Yes  No  
If yes, please list below the diagnosis, when, where, and by whom.

Please list any specific requests or anything else that we should know about you to help make your treatment experience more successful?