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California License PSY 21917
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PATIENT INFORMATION

Last Name	First Name

Parent/Guardian of Patient? Name: ______________________________ Relationship: _________________

Today's Date: ______/______/______ Gender: ___________________ Last four of SSN: ______________

Date of Birth: ______/______/______ Status: Single Married Divorced Widowed Other ________

Physical Address: ____ Apt. ______________

City: ____________________________________ State: _____________ Zip Code: __________

Billing Address: ____ Apt. ______________

City: ____________________________________ State: _____________ Zip Code: __________

Home: (______) _______- _________ **Cell**: (______) _______- _________ Work: (______) _______- _________
Primary? Primary? Primary?

Email: ____

Employer: ____ Occupation: ____________________________

Employer Address: ____________________________________ Employer Phone: (______) _______- _________

PRIMARY MEDICAL DOCTOR

Name & Practice: ____

Phone Number: (______) _______- __________ Fax Number: (______) _______- _________

EMERGENCY CONTACT

Name: ____________________________________ Relationship to you: _______________________________

Address: ____ Apt. _______________

City: ____________________________________ State: _____________ Zip Code: ___________

Daytime: (______) _______- ________ Evening: (______) _______- ________ Cell: (______) _______- ________

REFERRED BY

Name: _______________________________________ Flyer, From: _____________________________

Internet: Search Engine / Browser: _______________ RCVD Email, Re: ___________________________

Workshop, Title: _______________________________ Other: __________________________________

ADULT SYMPTOM CHECKLIST

The value of collecting baseline clinical information is to understand your concerns, to develop an appropriate plan for our work together, and to assess progress toward your goals.

Please note here in your own words the reason for seeking psychological services today. If the reason has been long-standing, please state what happened recently that led you to come at this time.

Please read both pages and check off all items that apply. Thank you.

Name ______________________________ Date ____________________

I feel sad or depressed.
I have felt very depressed daily for at least two weeks.
I have had similar episodes during my lifetime.
I have felt depressed for over two years.
I feel worthless or guilty.
I feel hopeless and helpless.
I have lost interest in usual daily activities.
I keep thinking about death.
I have thoughts about harming myself.
I have been thinking about suicide.
I have a plan to commit suicide.
I have been very tearful.

I have experienced periods of unexplainable high energy, elation, and confidence when other people thought I was not my normal self.
I have been experiencing irritability, anger, impatience, or flaring temper.
My emotions have been shifting rapidly without adequate control, such as sudden bursts of crying, shouting, arguing, or starting fights.
My thoughts have been racing, and I can't slow my mind down.

It is hard for me to focus my attention.
I am easily distracted by things around me.
I am restless, have a lot of "nervous energy."
I am having trouble making decisions.
I have trouble staying organized and on track.
It is difficult for me to start and complete tasks.
I get bored easily.

I feel edgy, keyed up.
I feel intense anxiety.
I have been worried or anxious most of the time in the last six months.
I startle very easily.

I repeatedly experience thoughts, images, memories, nightmares, or flashbacks about a horrifying event.
Sometimes I feel like I am re-experiencing the event.
I tense up when I am reminded of the event.
Significant parts of the event are difficult for me to recall.
Usually I just do not want to talk about the event.
I avoid reminders of the event (for example: activities, places, feelings, or people who bring it to mind).
I feel detached, in a daze, as if things are not real.
Sometimes I feel numb when I think I should be feeling emotions.
I've experienced an abrupt episode of intense fear.
I have had several panic attacks.
I fear getting another panic attack.
I worry about being stuck someplace, and experiencing anxiety or panic.
In unfamiliar situations, I scan the environment around me for possible problems.
I worry about losing control: "going crazy," or having a heart attack.
I have become much more careful.
I worry about being away from my home alone.

I fear or avoid some social situations (for example, crowds).
I fear or avoid some performance situations (for example, speaking before groups).
I fear a specific activity or action (for example, driving on the freeway).
I feel driven to do certain things over and over (for example, checking or counting things, repeating words silently, hand washing, hoarding, or exercising).
I have been engaging in excessive, impulsive, or risky behaviors (for example: in spending, gambling, eating or sexual behavior).

I have been experiencing unexplainable altered perceptual states.
I have been experiencing unreal or strange thoughts.
I have been experiencing unusual sensations of taste, smell, or touch.
I have been hearing noises or voices when there is no one there.
I believe someone wants to hurt me.
I have been experiencing the impulse to hurt myself or other people.

I tend to be a person who characteristically:
Is inhibited or detached from social relationships.
Is dependent and needs lots of reassurance.
Is perfectionistic and compulsive about details.
Is admired but also envied by others.
Is dramatic and emotional.
Experiences intense interpersonal relationships.
Is cautious and mistrustful of others.
Other people would call unusual or eccentric.
Does not conform to social norms or expectations.
My energy is low nearly every day and I am easily fatigued.
I have noticed a change in my appetite.
I have noticed a weight change.
I have begun to move more slowly.
I have difficulty falling or staying asleep through the night.
I need a lot less sleep than usual.
I have been sleeping a lot more lately.

I have ongoing muscle tension.
I experience frequent trembling and shaking.
I experience frequent sweating.
I get chills or hot flashes.
My heart beat is rapid or pounding.
I feel shortness of breath or smothering sensations.
I feel like I am choking.
I get chest pains or discomfort.
I feel nausea or abdominal distress.
I feel dizzy, unsteady, lightheaded, or faint.
I experience frequent numbness or tingling sensations.
I have been having problems functioning sexually.

I have been having trouble remembering facts.
I have been forgetting to take care of myself (for example, locking the door, turning off the gas, or taking medications).
I have been getting lost and having trouble knowing where I am.

The following medical problems have bothered me in the last year (for example, chronic pain, seizures, lapses of consciousness, obesity, diabetes, thyroid condition, tics, hypertension, malignancy, or cardiac disease):

My physician/psychiatrist has prescribed the following medications:
(Please include dosages and how frequently you take each.)

I sometimes help myself to feel better through using over-the-counter medications. Please list those medications:

I sometimes help myself to feel better through drinking alcohol or using other recreational drugs. Please list what and how much you use on average per day:

During the last year I have experienced:
Major change in work or school situation.
Major change in financial situation.
Major change in living situation or housing.
Major changes in family group or primary relationship.
Family conflict.
Chronic or disabling illness of family member.
Significant loss or rejection.
Exposure to disaster, either natural or man-made.
Legal problems.
Discrimination or harassment.
Victim or witness to crime.
Actual or threatened death or serious injury.
Unwanted pregnancy.

My present difficulties have been hindering me from being able to function in the following areas of life.
Job/school attendance.
Job/school performance.
Job/school relationships.
Marriage/intimate relationship.
Social relationships, friendships.
Parenting, child care, elder care.
Housework/work to maintain home.
Errands/routine activities.
Personal dress/hygiene.

PRIOR THERAPY

Are you currently receiving psychiatric services, professional counseling, or psychotherapy elsewhere?

Yes No If yes, with whom? ____

Have you had previous psychotherapy?

Yes No If yes, with whom? ____

SOCIAL INFORMATION

Are you currently in a romantic relationship? Yes No

If yes, how long have you been in this relationship? ____

On a scale of 1-10, how would you rate the quality of your current relationship? _______________________

OCCUPATIONAL INFORMATION

Are you currently employed? Yes No

If yes, who is your current employer/position? ____

If yes, are you happy at your current position? ____

Please list any work-related stressors, if any: ____

RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious? Yes No

If yes, what is your faith? ____

If no, do you consider yourself to be spiritual? Yes No

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Check any that apply and list the family member, e.g. sibling, parent, uncle, etc.)

Difficulty	Answer		Family Member
Depression	Yes	No	____________________________
Bipolar Disorder	Yes	No	____________________________
Anxiety Disorder	Yes	No	____________________________
Panic Attacks	Yes	No	____________________________
Schizophrenia	Yes	No	____________________________
Alcohol/Substance Abuse	Yes	No	____________________________
Eating Disorders	Yes	No	____________________________
Learning Disabilities	Yes	No	____________________________
Trauma History	Yes	No	____________________________
Suicide Attempts	Yes	No	____________________________

OTHER INFORMATION

What do you consider to be your strengths?

What do you like most about yourself?

What are effective coping strategies that you've learned?

What are your goals for therapy?

Finding Your ACE Score

While you were growing up, during your first 18 years of life;

1. Did a parent of other adult in the household **often or very often** …
   Swear at you, insult you, put you down, or humiliate you?
   OR
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes, enter 1 _______
2. Did a parent or other adult in the household **often or very often** …
   Push, grab, slap, or throw something at you?
   OR
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes, enter 1 _______
3. Did an adult or person at least 5 years older than you **ever** …
   Touch or fondle you or have you touch their body in a sexual way?
   OR
   Attempt or actually have oral, anal, or vaginal intercourse with you?
   Yes No If yes, enter 1 _______
4. Did you **often or very often** feel that …
   No one in your family loved you or thought you were important or special?
   OR
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes, enter 1 _______
5. Did you **often or very often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   OR
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes, enter 1 _______
6. Were your parents **ever** separated or divorced?
   Yes No If yes, enter 1 _______
7. Was your mother or stepmother …
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   OR
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   OR
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
   Yes No If yes, enter 1 _______
8. Did you live with anyone who was a problem drinker, alcoholic, or who used street drugs?
   Yes No If yes, enter 1 _______
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   Yes No If yes, enter 1 _______
10. Did a household member go to prison?
    Yes No If yes, enter 1 _______

Now add up your "Yes" answers: __________ This is your ACE score.