



If not currently prescribed psychiatric medication, have you been prescribed such medications in the past?  Yes  No

If yes, please list medication, dosage, and the approximate date treatment began and ended:

<i>Medication</i>	<i>Dosage</i>	<i>Reason Prescribed</i>	<i>Date Began/Ended</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you currently taking any other prescribed medication (e.g., for hypertension, migraines, etc.)?  Yes  No

If yes, please list medication, dosage, and the approximate date treatment began:

<i>Medication</i>	<i>Dosage</i>	<i>Reason Prescribed</i>	<i>Approx Date Began</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been hospitalized for psychiatric reasons?  Yes  No

If yes, what hospital, date began/ended, precipitating event:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## **PROBLEM ANALYSIS**

1. **PROBLEM DESCRIPTION:** Briefly **describe the problem and symptoms** for which you are currently seeking help.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. **PROBLEM INTENSITY:** How would you rate the intensity of the problem or concern that is bringing you in for help? (Circle the appropriate number):

1            2            3            4            5            6  
Not Intense            Moderately Intense            Extremely Intense

3. **PROBLEM DURATION:** Approximately how long have you had the current problem? \_\_\_\_\_

4. **PRECIPITATING EVENTS:** Were there any precipitating events (e.g. major family illness or death, divorce, moving to a new residence, etc.)?

\_\_\_\_\_

\_\_\_\_\_

5. COPING ATTEMPTS: In what ways have you attempted to **cope** with this problem?

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6. Have you noticed (or experienced) any of the following: Yes / No (briefly describe)

- a. Changes in amount of sleep (increased/decreased) **Yes / No** \_\_\_\_\_
- b. Difficulty falling or staying asleep **Yes / No** (if yes, circle appropriate description below)  
Sleeping too little    Sleeping too much    Poor quality sleep    Disturbing dreams    Other
- c. Loss of interest or pleasure in activities **Yes / No** \_\_\_\_\_
- d. Often feeling guilty or worthless **Yes / No** \_\_\_\_\_
- e. Changes in energy level during the day **Yes / No** \_\_\_\_\_
- f. Changes in concentration **Yes / No** \_\_\_\_\_
- g. Changes in appetite or weight - increase/decrease, how much? **Yes / No** \_\_\_\_\_
- h. Feeling physically slowed down or lethargic **Yes / No** \_\_\_\_\_
- i. Feeling agitated, jumpy, or unable to relax **Yes / No** \_\_\_\_\_
- j. Feeling that life is not worth living **Yes / No** \_\_\_\_\_
- k. Worrying excessively or without any apparent reason **Yes / No** \_\_\_\_\_
- l. Having episodes of sudden panic or intense fear **Yes / No** \_\_\_\_\_
- m. Wanting to hurt someone **Yes / No** \_\_\_\_\_
- n. Feeling in danger for no specific reason **Yes / No** \_\_\_\_\_
- o. Hearing, seeing, or feeling things that others do not **Yes / No** \_\_\_\_\_
- p. Getting special messages from the television, radio, magazines, etc. **Yes / No** \_\_\_\_\_
- q. Talking a lot more, or more rapidly than usual **Yes / No** \_\_\_\_\_
- r. Acting out of character, or behaving in ways that are later regretted **Yes / No** \_\_\_\_\_
- s. Feeling more energetic or needing much less sleep than usual **Yes / No** \_\_\_\_\_

**MEDICAL & HEALTH ISSUES**

- 1. How is your physical health at present?    Poor    Unsatisfactory    Satisfactory    Good    Very good
- 2. Please list any **persistent physical symptoms, chronic illnesses, or other health concerns** (e.g. chronic pain, headaches, fibromyalgia, diabetes, etc.):  
\_\_\_\_\_  
\_\_\_\_\_
- 3. How many times per week do you exercise? \_\_\_\_\_    For about how long each time? \_\_\_\_\_
- 4. Are you having any difficulty with **eating habits**? **Yes / No** (If yes, circle applicable response):  
Eating Less    Eating More    Binging    Restricting    Significant Weight Change  
(last 2 months)
- 5. Do you regularly use alcohol? **Yes / No**  
*How often do you use alcohol, and what do you typically drink?* \_\_\_\_\_  
*Have you used more alcohol or drugs than you intended this year?* **Yes / No**  
*Have you ever felt the need to cut down on the amount of alcohol you drink?* **Yes / No**  
Do you consider your alcohol consumption a problem? **Yes / No    Unsure**

6. How often do you engage recreational drug use?  
 Daily                  Weekly                  Monthly                  Rarely                  Never

*Have you ever felt the need to cut down on the amount of drugs you use? Yes / No*

List any recreation drugs you currently use and how often you use them:

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Do you consider this drug use a problem? **Yes / No**    **Unsure**

7. Is there a history of alcohol/substance abuse or dependence in your family? **Yes / No** (If yes, please specify)

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8. Is there a history of mental health concerns or mental illness in your family? **Yes / No** (If yes, please specify)

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9. Do you have any problems or worries about sexual functioning? **Yes / No** (If yes, circle applicable response):

Lack of desire      Performance Problem      Sexual Impulsiveness      Difficulties Maintaining Arousal  
 Worried about STDs (Sexually Transmitted Diseases)      Other

**SOCIAL HISTORY AND OTHER ISSUES**

1. Are any family members currently a source of support for you? **Yes / No**
2. Are any friends currently a source of support for you? **Yes / No**
3. About how many friends would you describe as *close*?    \_\_\_None    \_\_\_One    \_\_\_Two or three    \_\_\_Four or more
4. In the past, how would you rate the quality of your **peer relationships**?  
 Very Poor      Unsatisfactory About      Average      Good      Excellent
5. In approximately how many significant intimate relationships (e.g., lasting 6 months or more) have you been involved? \_\_\_\_\_

Are you in one now? **Yes / No** (If yes, please specify current length of relationship) \_\_\_\_\_ mos / yrs

6. Have you ever experienced sexual abuse, assault, or uncomfortable touching? **Yes / No**    **Decline to Respond**
7. Have you had suicidal thoughts recently? **Yes / No** (If yes, circle applicable response):  
 Frequently      Sometimes      Rarely      Never
8. Have you had them in the past? **Yes / No** (If yes, circle applicable response)  
 Frequently      Sometimes      Rarely      Never
9. Have you ever attempted suicide? **Yes / No** (If yes, please list the age(s) of the attempt(s)) \_\_\_\_\_
10. Have you ever intentionally inflicted any other form of harm upon yourself? **Yes / No**

