

Presenting Symptoms

Are you currently suicidal?	Y	N	Are you currently aggressive or violent?	Y	N
Suicidal thoughts only?	Y	N	Do you have aggressive/violent thoughts?	Y	N
Previous suicide attempts?	Y	N	Any past aggressive/violent acts/thoughts?	Y	N

Please Check all that apply:

Current	Past		Current	Past	
_____	_____	Depressed Mood	_____	_____	Fear of dying or going crazy
_____	_____	Daily irritability	_____	_____	Excessive fear-persons/places/animals/etc.
_____	_____	Lack of Interest/pleasure in activities	_____	_____	Recurrent & persistent thought/behaviors
_____	_____	Increase in appetite	_____	_____	Difficulty controlling anger/bad temper
_____	_____	Loss of appetite	_____	_____	Psychological abuse (emotional/verbal)
_____	_____	Difficulty sleeping or poor sleep	_____	_____	Physical abuse
_____	_____	Decreased need for sleep	_____	_____	Sexual abuse
_____	_____	Increased need for sleep	_____	_____	Distressing memories that reoccur
_____	_____	Restlessness/inability to concentrate	_____	_____	Recurrent distressing dreams
_____	_____	Difficulty making decisions	_____	_____	Delusions (unreasonable thoughts or beliefs)
_____	_____	Fatigue or loss of energy	_____	_____	Do you hear or see things that others don't?
_____	_____	Feelings of worthlessness or guilt	_____	_____	Not able to control impulse to steal
_____	_____	Feelings of hopelessness	_____	_____	Preoccupation with/or frequent gambling
_____	_____	Recurrent thoughts of death	_____	_____	Sense of reliving traumatic events
_____	_____	Racing thoughts or ideas	_____	_____	Periods of time you cannot remember
_____	_____	Rapid mood swings	_____	_____	Intense reactions to certain events or anniversaries
_____	_____	Shortness of breath/dizziness	_____	_____	Avoidance of thoughts or feelings of trauma
_____	_____	Accelerated heart rate or chest pains	_____	_____	Avoidance of activities or situations of trauma
_____	_____	Sweating/feeling flushed	_____	_____	Detachment from feelings, people and places
_____	_____	Choking	_____	_____	Binging/compulsive overeating
_____	_____	Nausea or abdominal distress	_____	_____	Intentional vomiting
_____	_____	Feeling unreal	_____	_____	Diuretics or laxative use
_____	_____	Numbness or tingling sensations	_____	_____	Excessive dieting
_____	_____	Sexual orientation issues	_____	_____	Compulsive exercising
			_____	_____	Compulsive sexual behaviors

Chemical Use History

Substances Used/Abused

Current	Past		Current	Past		Current	Past	
_____	_____	Alcohol	_____	_____	Marijuana	_____	_____	Other (identify)
_____	_____	Cocaine	_____	_____	Narcotics	_____	_____	_____
_____	_____	Ecstasy	_____	_____	hallucinogens	_____	_____	_____
_____	_____	Prescription Medication	_____	_____	Barbiturates	_____	_____	_____
_____	_____	OTC Medications	_____	_____	Amphetamines	_____	_____	_____

General Health Information

Current medical problems/concerns: Y N _____

Allergies: Y N _____ Disabilities: Y N _____ Weight Problems: Y N _____

Last medical examination date: _____ Primary Care Doctor: _____

Phone: _____