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:

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

Have you ever experienced any of the following:

Periods of at least 4 days when you were so happy or excited you got into trouble or others became worried about you?	□ Yes	□ No
Periods of at least 4 days of irritability or temper problems?	□ Yes	□ No
Racing thoughts or an inability to keep up with your thoughts?	□ Yes	□ No
Thoughts that others are "out to get you?"	□ Yes	□ No
Hallucinations (i.e. seeing, hearing, or feeling, something others cannot?	□ Yes	□ No
Memory problems?	□ Yes	□ 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	□ Yes	□ No	heart disease	□ Yes	□ No
diabetes	□ Yes	□ No	seizures	□ Yes	□ No
cancer	□ Yes	□ No			

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

depression	□ Yes	□ No	attention deficit	□ Yes	□ No
bipolar disorder	□ Yes	□ No	anxiety disorders	□ Yes	□ No
schizophrenia	□ Yes	□ No	alcoholism	□ Yes	□ No
mental retardations	□ Yes	□ No	drug addiction	□ Yes	□ No
learning problems	□ Yes	□ No	suicides/attempts	□ Yes	□ No
other (please describe)	□ Yes	□ No			

Family History

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

Please list all current psychiatric medications:

Medication	Dosage/Size	How long	Reason/Effect	Prescribing Clinician

Please list all other current medications including prescription and over the counter:

Medication	Dosage/Size	How long	Reason/Effect	Prescribing Clinician

Please list all past psychiatric medications:

Medication	Dosage/Size	How long	Reason/Effect	Prescribing Clinician

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?