CLIENT INFORMATION UPDATE - ADULT

Name:_____ Date: _____

Address:_____

City:_____State:_____Zip:_____

Phone: Cell:_____Ok to leave message? voice_____text _____

Work:_____Ok to leave message? _____

Home:_____Ok to leave message? _____

Email Address:_____Ok to leave message? _____

Partner's name, if applicable: _____

Person to notify in case of emergency: _____

Phone #_____Relationship to you: _____

Health and Treatment Update

Psychiatrist, APRN or other current Mental Health Providers:

_____

_____

Primary Care Physician: _____

Other physicians Involved in ongoing or chronic care:

_____

_____

_____

Current medications: (please include dose if known and prescribing doctor)

_____

_____

_____

Other significant health conditions or surgery:

_____

_____

Patient Name: _____

Therapy goals

Would you like to note any change in therapy goals?

_____

_____

_____

Current Problems and Symptoms

Please indicate the degree to which the following items are a problem to you in the past month by placing the appropriate number next to the problem.

1 – No Difficulty 2 – Mild Difficulty 3 – Great Difficulty 4 – Overwhelmed

_____ Job _____ School _____ Alcohol _____ Partner/Relationship

_____ Financial _____ Family _____ Drug Use _____ Sexual Activity

(Rate each problem 1 a little — 4 a lot and CIRCLE all words in parenthesis that pertain to you)

_____ Anxiety (Worry, fear, scared feelings, excessive guilt, anxiety attacks)

_____ Depression (unhappiness, hopelessness, lack of motivation, loss of enjoyment)

_____ Suicidal Thoughts (wishing you weren't alive, thoughts about suicide, suicide plan)

_____ Thinking (concentration, confusion, memory, intrusive, racing or obsessive thoughts)

_____ Attention (distractible, losing things, forgetting to do things, getting lost in your head)

_____ Hyperactivity (restless, talk too much or too fast, fidgety, always active)

_____ Confusion (problems knowing what's real, mind playing tricks, too suspicious or jealous)

_____ Physical Stress Symptoms (pain, headaches, fatigue, stomach aches, poor sleep, nightmares)

_____ Self Control (uncontrolled anger, overpowering sexual desires, addictive behavior)

_____ Emotions (change quickly, hard to control, control too much)

_____ Relationships with others (friend, co-worker, partner, family member)