SELF REPORT FORM

CHIEF CONCERN

Please describe the main difficulty that has brought you to see me:

_____

_____

YOUR MEDICAL CARE (From whom or where do you get your medical care?)

Clinic Name: _____ Doctor's Name: _____

Address: _____ Phone: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? **Yes** or **No** (circle one)

YOUR CURRENT EMPLOYER

Employer: _____ Work Phone: _____

Address: _____ Occupation: _____ How Long Employed by them: _____

Please indicate any restrictions on calls: _____

PRESENT RELATIONSHIPS

How do you get along with your spouse or partner: _____

How do you get along with your children: _____

Are or have there been other professionals/agencies involved in this issue you are having? Yes or No (circle one)

If so, who? _____ and when? _____

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services? **Yes** or **No** (circle one)

If so, please indicate which type of treatment: **Inpatient** **Outpatient** **Both** (circle one)

If so, please indicate: When?_____ From Whom? _____

For What? _____ Results: _____

Have you ever taken medications for psychiatric or emotional problems? **Yes** or **No** (circle one)

If so, please indicate: When?_____ From Whom? _____

For What? _____ Results: _____

Please check any of the following that have been bothering you lately:

[ ] Inferiority Feelings	[ ] Marriage	[ ] Nightmares	[ ] Obsessive Thinking	[ ] Sexual Problems	[ ] No Interests
[ ] Children	[ ] Shyness	[ ] Separation	[ ] Drug Use/Abuse	[ ] Anger	[ ] Nervousness
[ ] Sleep	[ ] Relaxation	[ ] Painful Thoughts	[ ] Energy (hi/low)	[ ] Legal Matters	[ ] Friends
[ ] Compulsivity	[ ] Fetishes	[ ] Impotence	[ ] Loneliness	[ ] Suicidal Thoughts	[ ] Education
[ ] Guilt	[ ] Bowel Trouble	[ ] Depression	[ ] Divorce	[ ] Alcohol Use	[ ] Compulsions
[ ] Self-Control	[ ] Ambition	[ ] Spacing Out	[ ] Making Decisions	[ ] Perfectionism	[ ] Conflict
[ ] Sexual Orientation	[ ] Insomnia	[ ] Agoraphobia	[ ] Appetite	[ ] Fears	[ ] Finances
[ ] Confidence	[ ] Unhappiness	[ ] Health Problems	[ ] Stress	[ ] Relationships	[ ] Tiredness
[ ] Self Esteem	[ ] Anxiety	[ ] Phobias	[ ] Extreme Fatigue	[ ] Panic Attacks	[ ] Overweight
[ ] Sexual Abuse	[ ] Stomach Trouble	[ ] Abused as Child	[ ] Short Temper	[ ] Work	[ ] Memory
[ ] My Thoughts	[ ] Sadness	[ ] Homicidal	[ ] Eating Problem	[ ] Headaches	[ ] Career Choice
[ ] Concentration	[ ] Being a Parent				

Please indicate how the issue(s) for which you are seeking treatment are effecting the following areas of your life:

MARRIAGE / RELATIONSHIP					
[ ] No Effect	[ ] Little Effect	[ ] Some Effect	[ ] Much Effect	[ ] Significant Effect	[ ] NA
FAMILY					
[ ] No Effect	[ ] Little Effect	[ ] Some Effect	[ ] Much Effect	[ ] Significant Effect	[ ] NA
JOBS / SCHOOL PERFORMANCE					
[ ] No Effect	[ ] Little Effect	[ ] Some Effect	[ ] Much Effect	[ ] Significant Effect	[ ] NA
FRIENDSHIPS					
[ ] No Effect	[ ] Little Effect	[ ] Some Effect	[ ] Much Effect	[ ] Significant Effect	[ ] NA
FINANCIAL SITUATION					
[ ] No Effect	[ ] Little Effect	[ ] Some Effect	[ ] Much Effect	[ ] Significant Effect	[ ] NA
PHYSICAL HEALTH					
[ ] No Effect	[ ] Little Effect	[ ] Some Effect	[ ] Much Effect	[ ] Significant Effect	[ ] NA
ANXIETY LEVEL / NERVES					
[ ] No Effect	[ ] Little Effect	[ ] Some Effect	[ ] Much Effect	[ ] Significant Effect	[ ] NA
MOOD					
[ ] No Effect	[ ] Little Effect	[ ] Some Effect	[ ] Much Effect	[ ] Significant Effect	[ ] NA
EATING HABITS					
[ ] No Effect	[ ] Little Effect	[ ] Some Effect	[ ] Much Effect	[ ] Significant Effect	[ ] NA
SLEEPING HABITS					
[ ] No Effect	[ ] Little Effect	[ ] Some Effect	[ ] Much Effect	[ ] Significant Effect	[ ] NA
SEXUAL FUNCTIONING					
[ ] No Effect	[ ] Little Effect	[ ] Some Effect	[ ] Much Effect	[ ] Significant Effect	[ ] NA
ALCOHOL / DRUG USE					
[ ] No Effect	[ ] Little Effect	[ ] Some Effect	[ ] Much Effect	[ ] Significant Effect	[ ] NA
ABILITY TO CONCENTRATE					
[ ] No Effect	[ ] Little Effect	[ ] Some Effect	[ ] Much Effect	[ ] Significant Effect	[ ] NA
ABILITY TO CONTROL ANGER					
[ ] No Effect	[ ] Little Effect	[ ] Some Effect	[ ] Much Effect	[ ] Significant Effect	[ ] NA

SUBSTANCE USE

Do you currently consume alcohol? **Yes** or **No** (circle one)

If yes, on average how many drinks per occasion do you consume? _____

How many days per week do you consume? _____

Do you have a history of problematic use of alcohol? **Yes** or **No** (circle one)

Have family members or friends expressed concern about your drinking? **Yes** or **No** (circle one)

Do you currently use non-prescribed drugs or street drugs? **Yes** or **No** (circle one)

Do you have a history of problematic use of prescription or non-prescription drugs? **Yes** or **No** (circle one)

Do you have a family history of alcohol or drug problems? **Yes** or **No** (circle one)

If yes, please describe: _____

_____

_____

Other important medical information including current medications: _____

_____

_____

_____

OTHER

Please list the names of all family members living in your household, their relationship to you and their age (include yourself).

Name	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Religious Preference:_____ Do you want prayer to be a part of your session with the Therapist? [ ] yes [ ] no

Is there anything else that is important for me as your therapist to know about and that you have not written about on any of these forms? Please tell me here:

_____

_____

_____

_____

_____