PATIENT SYMPTOM / HISTORY CHECKLIST

Patient Name ______________________ Date __________

Referral Source ______________________ Age ______ Marital Status ______ Children ______

1. Activity

		How Long
Decrease in energy or fatigue	___	___
Hyperactive Increased Energy/Activity	___	___
Impulsive	___	___
Decreased Activity Level	___	___
Restlessness	___	___

2. Behavior

Less productive at school or work	___	___
Academic or work inhibition	___	___
Aggression or rage	___	___
Compulsive Behavior	___	___
Deceitfulness or theft	___	___
Destructive	___	___
Disorganized	___	___
Reckless	___	___
Self-injurious	___	___
Social Withdrawal	___	___
Violation of rules or rights of others	___	___
Suicide Attempt	___	___

3. Anxiety/Phobia

Anxiety	___	___
Fear of being alone	___	___
Jitteriness	___	___
Panic Attacks	___	___
Irrational Fear	___	___
Anxiety related physical symptoms	___	___
Worrying, obsessive thoughts	___	___

4. .Mood/Affect Disturbance

		How Long
Anger	___	___
Apathy	___	___
Feeling Numb	___	___
Depressed Mood	___	___
Exceptionally Good Mood	___	___
Excessive or inappropriate guilt	___	___
Excitability	___	___
Feeling Worthless_	___	___
View self as special and worthy of admiration	___	___
Helplessness	___	___
Hopelessness	___	___
Irritability	___	___
Hostility	___	___
Loss of interest or pleasure	___	___
Low self-esteem	___	___
Mood Swings	___	___
Tearfulness	___	___

5. Sleep Disturbance

Early morning awakening	___	___
Sleeping too much	___	___
Insomnia	___	___
Nightmares	___	___

6. Thinking/Memory/Attention

Diminished ability to think	___	___
Distractability	___	___
Impaired abstract thinking	___	___
Impaired judgment	___	___
Indecisiveness	___	___
Memory problems	___	___
Poor attention or concentration	___	___

7. Form and Amount of thought/speech

Thoughts come very rapidly	___	___
More talkative than usual	___	___
Pressured Speech	___	___
Slurred speech	___	___
Others have trouble following my thoughts when I'm speaking	___	___

8. Perception and Thought Problems

		How Long
Hearing voices	___	___
Increased suspiciousness	___	___
Recurrent memories of distressing events	___	___
Flashbacks	___	___
Suicidal thoughts	___	___

9.Physical Signs and Symptoms

Chronic pain	___	___
Chronic medical problems	___	___
Physical disability	___	___

10. Eating Disturbance

Deliberately restricting food intake	___	___
Overeating	___	___
Binge eating	___	___
Decreased appetite	___	___
Increased appetite	___	___
Striving to maintain thin figure	___	___
Self-induced vomiting	___	___
Other purging (laxative, diuretics) etc	___	___
Compulsive exercise	___	___
See self as heavier than others see me	___	___
Intentional weight loss (___lbs.)	___	___
Unintentional weight loss (___ lbs.)	___	___

11. Substance Abuse

		How Long
Cont. use in spite of problems/consequences	___	___
Disrupts daily functioning (social or work)	___	___
Inability to decrease use	___	___
Persistent desire for substance	___	___
Needing more of substance to get same effect	___	___
Withdrawal	___	___
Excessive time spent to obtain, use or recover from effects	___	___

12. Other Symptoms

______________	___	___
______________	___	___
______________	___	___
______________	___	___
______________	___	___

Reason you came to us for help: ________________________________

____

____

____

When did the above problem(s) start: ________________________________

____

____

____

Family History

Depression ______
Mania ______
Anxiety ______
Eating Disorder ______
Schizophrenia ______
hearing voices, out of touch with reality ______
Drug or alcohol abuse ______
Obsessive-compulsive problems ______
ADD/ADHD ______
Suicide Attempts ______
Psychiatric hospitalizations ______
Other psych problems (specify) ______

Previous Mental Health Treatment

Counseling (name of therapist): ______
Time frame ______
Nature of problem ______
How helpful was this counseling experience? ______
Inpatient treatment (where, nature of problem, time frame) ______

Psychiatric medication (Dr's name, time frame, was medication helpful?) ______

Medical History

Please list any medical problems: ______

Current medications (name, dose, frequency) ______

List all Physicians from whom you receive care: ______

Personal Social History – check all that apply to your history

		Age/age range at time of occurance
Dysfunctional family background	____	________
Problems in school with behavior	____	________
Problems in school with grades	____	________
Problems on the job	____	________
Punished physically	____	________
Physically abused	____	________
Sexually abused	____	________
Emotionally/verbally Abused	____	________
Divorced	____	________
Widowed	____	________
Significant death/ loss (specify)	____	________
Teased/harassed in school	____	________
Financial irresponsibility	____	________
Problems with social adjustment	____	________
Unwanted pregnancy	____	________
Problems with sexual adjustment	____	________
Past alcohol abuse	____	________
Past drug abuse	____	________
Legal issues	____	________

Other ______