2323 21st Ave. S. Nashville, TN 37212 615-417-9707

Please provide the following confidential information. Please Print.

Today's Date: _____________

Client Name____ **Preferred Name**_____________________
First Middle Last

Date of Birth____________________________ **Age**_____________

Sex: F M Other or Gender Identity:_____________________________ (Specify if comfortable doing so)

Race/Ethnicity____ **Country of Origin**__________________

Religious Affiliation or Spiritual Practice (if applicable) ____

Primary Care Physician____________________________________ **Date of Last Exam**___________________

Psychiatrist (if applicable)____________________________________ **Date of Last Appointment**__________

Relational Status: Single Partnered Committed Other: ___________________________________

Length of Current Relationship______________

Sibling(s) Names/ Age(s) ____
____
____

How were you referred to my practice?:____

Do You Have Any Medical Problems or History of Medical Problems? Yes No If Yes, Please Explain:
____
____
____
____
____

Current Medications & Dosage (Prescription/Herbal/Other): **Prescribed by:**
____
____
____
____
____
____

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Listing of Prior Treatment

Beginning with the most recent, please list all professionals (psychologists, psychiatrists, counselors, social workers, pastoral counselors, etc.) and facilities (hospitals, alcohol and drug programs, clinics, etc.) that have provided psychological evaluation and/or treatment.

Patient Initials	Type of Service (counseling, hospitalization, etc)	Provider	Dates of Service

Has anyone in your family (blood relatives) ever been diagnosed with a mental illness?___________________

____

____

____

____

Has anyone in your family ever attempted suicide?____

____

____

____

____

My symptoms include (Circle all that apply):

sadness irritability insomnia crying spells suicidal thoughts

no pleasure no energy trouble sitting still trouble concentrating fear

changes in appetite sleeping too much low self-esteem troubling thoughts

feeling paranoid feeling out of control thoughts of harming others

confused or forgetful alcohol abuse hopelessness helplessness

excessive or inappropriate guilt excessive or inappropriate anger worrying

panic attacks indecisiveness impulsivity racing thoughts

irritability relationship difficulties physical symptoms_________________________________

Others:____

Briefly Describe the Main Problems/Reasons That Bring You Here:

____

____

____

____

____

____

What Would You Like To Achieve and/or See Happen By Coming Here For Care?

____

____

____

____

What kinds of physical activity do you get?

____

____

Do you try to restrict your eating in any way? ____No ____Yes If Yes, how? ____________________________

____

____

Do you have any problems getting enough sleep? ____No ____Yes If Yes, what problems? _______________

How many cups of regular coffee do you drink each day? _____ How many cups of tea? ____

How many sodas with caffeine? ____ How many "energy drinks"? ____ How often do you use caffeine pills? _______ How much tobacco do you smoke or chew each week? _______________________________ How much beer, wine, or hard liquor do you consume each week, on average? _______________________

Have you ever felt the need to cut down on your drinking? ____No ____Yes

Have you ever felt annoyed by criticism of your drinking? ____No ____Yes

Have you ever felt guilty about your drinking? ____No ____Yes

Have you ever felt you needed a drink first thing in the morning to steady your nerves or get rid of a hangover? ____No ____Yes

Have you ever had a DUI? ____No ____Yes If yes, when and where? ____________________________________

Have you ever had an alcohol or drug-related arrest? ____No ____Yes If yes, when, and what was

the charge?: ____

Which drugs (not medications prescribed for you) have you ever used? Note how often you have used, their effects, and so forth.

____

____

____

Have you ever been exposed to or witnessed any of the following: actual or threatened death, actual or threatened serious injury, or actual or threatened sexual violence? ____No ____Yes If yes, please explain:

____

____

Have you ever been abused in any way? ____No ____Yes If yes, ___Emotional ____Physical ____Sexual

When and by whom: ____

____

How did/do your parents/caregivers get along with each other?

____

____

____

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How were/are your relationships with parents/caregivers? ____

____

____

How do you get along with your siblings?

____

____

____

Did anyone in your family abuse alcohol or drugs, experience mental or emotional difficulties, or have serious medical concerns? ____No ____Yes If yes, please explain: ______________________________________

____

____

Has anyone in your family been diagnosed with a mental illness? ____No ____Yes If yes, please explain:

____

____

Has anyone in your family ever attempted suicide? ____No _____Yes If yes, please explain: ______________

____

____

How do you get along with friends? Are you satisfied with your social support? __________________________

____

____

L. Is there any other information you think I should know about your health or history?