QUADRA Counseling Associates, LLC

PATIENT INFORMATION

Name: _____ **DOB:** _____ **Date:** _____

Address: _____ **Home Phone:** _____

Town/State/Zip: _____ **Cell Phone:** _____

Symptoms: (check all that apply)

- ❑ Depressed Mood
- ❑ Decreased Energy
- ❑ Grief
- ❑ Hopelessness
- ❑ Worthlessness
- ❑ Guilt
- ❑ Anxiety
- ❑ Panic Attacks
- ❑ Obsessive Behavior
- ❑ Elevated Mood
- ❑ Irritability
- ❑ Impulsiveness
- ❑ Appetite Problem
- ❑ Hyperactivity
- ❑ Disruption of Thought Process/Content
- ❑ Delusions
- ❑ Visual Hallucinations
- ❑ Audio Hallucinations
- ❑ Oppositional/Defiant Behavior
- ❑ Difficulty with Sleep
- ❑ Difficulty Concentrating
- ❑ Emotional Trauma
- ❑ Physical Trauma
- ❑ Sexual Trauma
- ❑ Substance Abuse
- ❑ Other (specify)

_____

Symptoms have been present for:

❑ Less than 1 month ❑ 1-6 months ❑ 6-12 months ❑ 12 months or more

How have these symptoms/events affected/impacted the way you live your life?

	No impact	Mild impact	Moderate impact	Marked impact	Severe impact
Marriage/Relationship	1	2	3	4	5
Family/Job/School Performance	1	2	3	4	5
Friendship/Peer Relationships	1	2	3	4	5
Hobbies/Interests/Play Activities	1	2	3	4	5
Physical Health	1	2	3	4	5
Daily Activities (hygiene, bathing, etc.)	1	2	3	4	5
Eating Habits	1	2	3	4	5
Sleeping Habits	1	2	3	4	5
Sexual Functioning	1	2	3	4	5
Ability to Concentrate	1	2	3	4	5
Ability to Control Temper	1	2	3	4	5

Name: _____ **DOB:** _____ **Date:** _____

What event(s), problem(s) or issue(s) are causing you to seek treatment?

Who are the members of your immediate family: spouse, children etc. and/or family of origin: parents/siblings. With whom do you currently reside?

Has any family member ever been treated (by medication or counseling) for depression or other emotional problems? If so, briefly describe who, when, type of problem and medications used (if any).

Has anyone in your family ever tried to commit suicide? If so, who, when, how many times, and what happened?

Have you recently thought about killing yourself? If so, how are you planning on doing this? How would you rate the likelihood you will actually try – on a scale of 1 to 10, 1 being no way you will try and 10 being it is very likely you will try?

Are you worried about anyone in your immediate family (including yourself) becoming violent? If so, describe.

Have you ever been raped or a victim of physical violence (including childhood abuse or sexual molestation)? If so, please describe when, who did it, the circumstances, and how you think it has affected you.

Do you have any faith/religious type beliefs? If so, please indicate the faith (Islam, Christianity, Judaism, Atheism, etc.) and what role it plays in your life.

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Do you have a concern about the drinking or drug use of anyone in your family (including spouse, children, or yourself)? If so, who and what is your concern?

What is your current pattern of drinking and/or drug use (what, how often)?

Have you ever used Cocaine? Heroin? Marijuana? Other? If so, note how long ago and how often.

Do you smoke cigarettes? If so, how long have you done so and how much do you smoke?

Are you currently being treated for any medical problems? If so, list any medications and your physician(s) name(s).

Please list any major medical conditions you have had in the past; also, any conditions in your family of origin that are significant to you.

Have you ever been convicted of a crime (other than minor traffic violations)? If so, list what and when.

Have you had other experiences with another therapist or counselor or psychologist or psychiatrist? If so, was there anything particular you liked or disliked? If so, describe.

List two or three <u>specific</u> goals you want to be sure to accomplish in therapy.

Is there anything else you would like me to know?

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EMERGENCY CONTACT INFORMATION

NOTE: In the event of an emergency, the information provided below will help us provide the best care possible. This information will not be used unless there is an emergency and by providing this information, you are giving us permission to contact any and/or all of these people in the event of an emergency.

Contact's Name: _____ **Relationship to you:** _____

Address: _____

Town/State: _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Physician: _____ **Phone:** _____

Psychiatrist: _____ **Phone:** _____

Allergies and/or relevant emergency information: _____

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