



Northwest Psychological Center

CONFIDENTIAL INFORMATION

(Thank you for choosing our office for your mental health needs. In order to better serve you, we would appreciate it if you would provide the following information. This information is confidential.)

Client name: _____ Phone #: _____

How were you referred to our office?

- | | |
|--|--|
| <input type="checkbox"/> Your doctor | <input type="checkbox"/> Insurance company |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Yellow Pages |
| <input type="checkbox"/> Family member | <input type="checkbox"/> Other: _____ |

Family doctor: _____

Briefly describe what brings you in to Northwest Psychological Center at this time:

Please check those symptoms that you have regularly experienced during the past month:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Prior suicide attempt | <input type="checkbox"/> Too much sleep |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Slowed thinking | <input type="checkbox"/> Wish to die | <input type="checkbox"/> Angry feelings |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Guilt | <input type="checkbox"/> Confusion | <input type="checkbox"/> Panic feelings |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Unusual experiences | <input type="checkbox"/> Fear | <input type="checkbox"/> Unsure of reality |
| <input type="checkbox"/> Lack of energy | <input type="checkbox"/> Physical violence | <input type="checkbox"/> Memory problems | <input type="checkbox"/> Unsure of identity |
| <input type="checkbox"/> Excess energy | <input type="checkbox"/> Hopeless feelings | <input type="checkbox"/> Concentration problems | <input type="checkbox"/> Drinking problem |
| <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Too little sleep | <input type="checkbox"/> Dizzy spells |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Compulsive dieting | <input type="checkbox"/> Other: _____ |

How long have you had these symptoms? _____ years _____ months

How have these symptoms effected your everyday functioning?

Current stressors: (Please list)

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Have you ever been in counseling or therapy previously? Yes No (If yes, complete below):

<u>Where:</u>	<u>Dates:</u>	<u>Therapist:</u>	<u>Reason:</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



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Have you ever been in a psychiatric hospital? Yes No (If yes, complete below)

Date:

Reason:

Please describe what you hope to accomplish in therapy (what are your expectations):

Are there any reasons that you can foresee that would prevent you from staying in treatment?

If therapy is not progressing according to expectations, are you likely to: drop out of treatment or discuss this with your provider?
