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?

[ ] Your doctor [ ] Insurance company
[ ] Friend [ ] Yellow Pages
[ ] Family member [ ] Other: _____________________

Referring doctor: ____

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

____

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

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[ ] Withdrawn	[ ] Suicidal thoughts	[ ] Too little sleep	[ ] Dizzy spells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

How long have you had these symptoms?____________years ________________months

How have these symptoms effected your everyday functioning?

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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):

Where:	*Dates:*	*Therapist:*	*Reason:*
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________

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?