COGNITIVE THERAPY & CONSULTATION, LLC

Date:

Name:_______________________________ Phone number (   ) _____-_________

May I leave a message for you on this phone? Yes__ No__

Age: ____ Birthdate: ______ E-mail ________________________(OK to leave appointment information only?)Yes or No

1. Main reason/s you are seeking this evaluation/treatment**:**

____
____
____
____

2. When did you first notice this problem?

____
____
____

3. Please describe any other concerns below**:**

____
____
____

4. When did you first notice this/these problem/s?

____
____
____

5. Please list/describe any other stressors in your family at this time:

____
____
____
____

6. Have you been seen by a mental health professional or received psychiatric services in the past?
No (__) Yes (__) (If yes, please complete grid below.)

Date	By Whom	Findings/Diagnoses	Treatments/Medications

7. Which psychotropic medications do your take or have you taken?
Drug Dose When (mo./yr.) Did it help? Side effects?

Family Psychiatric History: (Please circle any of the following that exist in either side of your biological family and specify which family member.)

Biological family members**:**

Alcohol Abuse ___ family member(s): ________________

Anxiety ____ family member(s): ___________________________

Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder____;

family member(s): ____________________________

Bipolar Disorder ___ family member(s):_____________________________

Depression ___ family member(s):_____________________________

Drug abuse __ family member(s): _____________________________

Learning Disorder __ family member(s): _____________________________

Schizophrenia ___ family member(s):_ ____________________________

Suicide Attempt ___ family member(s):_____________________________

Has anyone in your family had previous mental health treatment or substance abuse**?**
No (___) Yes (___) (If yes, please describe):
____
____
____
____

Have you ***or*** *anyone in your family* been hospitalized for a mental illness**?**
No (___) Yes (____) (If yes, please explain):
____
____
____

Do you use any of the following**:**
Caffeine No (___) Yes (___) (If yes, please describe frequency and amount, to your knowledge)

Tobacco No (___) Yes (___) (If yes, please describe frequency and amount, to your knowledge)

Alcohol No (___) Yes (___) (If yes, please describe frequency and amount, to your knowledge)

Marijuana No (___) Yes (___) (If yes, please describe frequency and amount, to your knowledge)

Drugs No (___) Yes (___) (If yes, please describe frequency and amount, to your knowledge)

Please check if you have had any of the following medical problems in the past 3 years:

___ Frequent headaches ___ Vision problems
___ Seizures
___ Serious head injury or concussion (if yes, please describe):
Are you involved in a lawsuit? Y or N

___ Unusual movements/motions ___ Sexually Transmitted Disease (STD)
___ Trouble sleeping ___ Poor appetite
___ Cancer ___ Fainting spells
___ High blood pressure ___ Tics or other habits
___ Urinary tract infection (UTI) ___ Frequent stomach aches
___ Hearing problems ___ Frequent ear infections

___ Surgery (if yes, please describe): ____

___ Hospitalization (if yes, please describe):____

Are you allergic to anything? No (___) Yes (___) (If yes, please describe):

Please list any medications you are currently taking, including the dose and prescribing physician:

Medication	Dose	Physician

Your primary physician: Name ____
Telephone Number:
(___) ____ _________

Marital status and current living situation (Please check both marital status and living arrangement :

___Married ___ Domestic Partnership ___Single ___ Separated ___ Divorced
___Widow/er

___ Live with spouse/partner and children
___ Live with spouse/partner ___ Live with parent/s
___ Live alone ___ Live with roommate/friend
___ Live with children ___ Other (describe __________
___ Pets? if yes, how many ___

Household Composition

Name /Relationship	*Age*	*Name/Relationship*	*Age*
_____________________________	_____	_______________________	_____
_____________________________	_____	_______________________	_____
_____________________________	_____	_______________________	_____
_____________________________	_____	_______________________	_____
_____________________________	_____	_______________________	_____

Employment Status : __ Full time___ Part time __ Not Working __ Retired
If employed, occupation: _________________________ ___ Student ___ Homemaker

Education: Highest grade completed: _______________

<table>
<tr><td colspan="3">Problem Checklists: Please circle any of the following problems that you have now.</td></tr>
<tr><td>Finishing tasks
Distractible
Disorganized
Forgetful
Can't sit still
Impulsive
Interrupt people
Short tempered

Shy
Worried
Aloof
Avoid eye contact</td><td>Irritable
Angry

Use drugs
Use alcohol
Use tobacco

Sexually active
No sexual desire
Other sexual issues

____

Indiscriminately affectionate</td><td>Depressed
Not interested in things
Weight change gain loss
Appetite change
Sleep change:* see below--
Agitation
Fatigue
Feel worthless
Feel guilty
Poor concentration
Indecisive
Crying spells
Thoughts of death
Thoughts of suicide
Suicide plan
Suicide attempt</td></tr>
<tr><td>Pick at skin
Pull hair
Cutting</td><td>History of:
Physical abuse
Sexual abuse
Mental abuse
Neglect</td><td>Don't want to eat
Binge
Vomit
Use laxatives for weight loss
Feel fat
Feel ugly</td></tr>
<tr><td>Anxious
Heart palpitations
Sweating
Trembling
Shortness of breath
Choking
Chest pain
Nausea
Diarrhea
Dizziness
Faintness
Feel unreal
Feel detached from self
Fear losing control
Fear dying
Numb
Tingling
Chills
Hot flashes
Don't like to be home alone
Don't like to leave home</td><td>See things that aren't there
Feel no emotion
Don't trust others
Hear voices
____

Sleep disturbances?*

Falling asleep?

Early waking?

Interrupted sleep?

Nightmares?</td><td>Relating to others
Can't sustain conversation
Odd thoughts
Need routines
Use rituals
Comfort in repetitive activities
Avoid things/objects/people
Describe

____
Legal Problems

Occupational Problems

School Problems

Social Problems</td></tr>
</table>

Thank you for taking the time to complete this form.

Is there any other information you'd like me to know?