CONCERNS, MEDICATION INFORMATION, ALLERGIES/SENSITIVITIES

Client Name: _____ Date: _____

Briefly explain why you are seeking counseling: _____

_____

_____

Have you received psychiatric treatment or counseling before? □ Yes □No

If so, when? _____

Name(s) of psychiatrist(s) or counselor(s) _____

Check any of the following items that have caused or are causing you concern:

□ Nervousness	□ Depression	□ Fears	□ Shyness
□ Divorce	□ Sexual problems	□ Separation	□ Finances
□ Anger	□ Drug abuse	□ Alcohol abuse	□ Friends
□ Stress	□ Self-control	□ Hearing voices	□ Sleep
□ Violent thoughts	□ Work	□ Relaxation	□ Headaches
□ Energy	□ Memory	□ Ambition	□ Legal matters
□ Concentration	□ Insomnia	□ Making decisions	□ Loneliness
□ Health problems	□ Inferiority	□ Education	□ Marriage
□ Children	□ Temper	□ Nightmares	□ Career Choices
□ Parenting	□ Appetite	□ Stomach problems	□ Bowel problems
□ Eating Disorder	□ Negative thoughts	□ Sexual identity	□ Fatigue

Other: _____

Please list any prescriptions and over-the-counter medications you take on a regular basis

I am currently taking:	For this condition:	Prescribing Physician Name:

□ I do not take any prescription or over-the-counter medications

Please list any known allergies/sensitivities and your reaction to it/them

I am allergic/sensitive to:	My reaction

□ I have no allergies or sensitivities