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Intake Symptom Checklist

Name: _____

Date: _____

Age: _____

Date of Birth: _____

Please briefly note the particular current concerns bringing you to our practice:

Please check any of the following experiences which apply to you. Feel free to add any pertinent information in the margins.

Mood Problems

Sadness

Negative self-concept

Brooding / Stewing over negative thoughts

Crying

Loss (check all that apply)

Loved one Job Home Other

Grief

Depression

Increase/Decrease Appetite

Loss of interest in previously pleasurable activity

Low energy

Change in sleep -- too much sleep / insomnia

Decreased libido

Anger

Mania / too much energy / decreased need for sleep

Thought Processes

Obsessive thinking

Racing thoughts

Difficulty concentrating

Easily distracted

Forgetfulness

Getting lost in previously familiar locations

Self Regulation (Attention Deficit /Hyperactive Symptoms)

Hyperactivity

Impulsivity

Difficulty keeping up with personal items

Difficulty breaking large tasks down into smaller, more manageable components

Being easily distracted / difficulty concentrating

Forgetfulness

Difficulty following through and completing tasks

Anxiety Symptoms

Feeling anxious or nervous much of the time

Fears / specific phobias (Specify: _____)

Panic attacks

Obsessive or repetitive thoughts that won't go away

Repeating behaviors excessively (e.g., checking locks, washing hands repeatedly)

Fear of encountering others in social situations

Extreme anxiety in public speaking

Excessive shyness

Interpersonal Concerns

Social isolation / withdrawal from others

Being overly dependent on others

Being overly concerned with what others think about you

Having your feelings hurt easily

Excessive care-taking

Problems taking care of self

Difficulty with assertiveness / speaking your mind

Difficulty with communication

Family problems

Parenting concerns

Marital problems

Other love relationship problems

School or occupational difficulties

Problems with sexual functioning

Physical Problems

Headaches

Physical illness

Chronic pain

Menstrual problems

Physical problems in sexual functioning

Head injury

Other serious injury

Additional Symptoms

Being unable to account for your daily activities during periods of time

Seeming to “space out” / detachment or depersonalization

Flashbacks from previous drug use

Seeming to “numb out” or go blank at times

Hearing things / auditory hallucinations

Seeing things / visual hallucinations

Traumatic Experiences

History of abuse from others

Emotional

Verbal

Physical

Sexual

History of abuse toward others

Emotional

Verbal

Physical

Sexual

Currently in danger of harming others

Currently in danger of harm from others

Currently in danger of harming self

Thoughts of suicide

Suicide plan

Cutting / self mutilation

Experience of a traumatic event

Combat veteran

Violent Crime victim

Sexual Crime/rape victim

Accident / fire

Natural disaster

Tragic accident /victimization / death of a loved one

Flashbacks to a traumatic event

Nightmares / troubling dreams

Avoidance behavior following a traumatic experience

Addictive or Compulsive Behaviors

Self

Family Member

- Alcohol overuse or abuse
- Street drug use
- Sexual addiction
- Romance / relationship addiction
- Compulsive gambling
- Compulsive shopping
- Compulsive overeating or diet restriction
- Compulsive exercise
- Compulsive overwork
- Compulsive overuse of Internet
- Other compulsive behavior (Specify: _____)

Please list current medication, dosage, and prescribing physician:

Medication Name	Dosage	Date Started	Prescribing Physician

Please put additional medications on the back of this sheet.

Primary Care Physician Name: _____ Phone: _____

Date of last physical examination: _____
 Please describe any significant medical concerns:

Please describe previous psychiatric or psychotherapy treatment, inpatient or outpatient, with dates and outcomes:

Family history of psychological symptoms: _____

Maternal family: _____

Paternal family: _____

Educational History:

Current occupation and history:

Marital status/name and age of spouse or partner:

Do you have children? If so:

Name Age

Other pertinent information or history about yourself not previously covered that you feel may be helpful to your psychologist in helping you: