Adult Self Report Form

Chief Concern:

Please describe the main difficulty that has brought you to see me:

Your medical care (From whom or where do you get your medical care?)

Clinic name: Phone:

Doctor's name: Address:

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment?!

◯ YES ◯ NO

Your current employer

Employer: Work phone:

Address: Occupation:

Length of time with this employer:

Please indicate any restrictions on calls:

Present relationships

How do you get along with your spouse or partner?

How do you get along with your children?

Past Psychological/Psychiatric Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services?

◯ YES ◯ NO

Please indicate which type of treatment:

◯ Inpatient ◯ Outpatient ◯ Both

If yes, please indicate:

When

From Whom

For What

Results

Have you ever taken medications for psychiatric or emotional problems?

◯ YES ◯ NO

If yes, please indicate:

When

From Whom

For What

Results

List of Symptoms

Please check any of the following that have been bothering you lately:

- ☐ inferiority feelings
- ☐ marriage
- ☐ nightmares
- ☐ obsessive thinking
- ☐ sexual problems
- ☐ no interests
- ☐ children
- ☐ shyness
- ☐ separation
- ☐ drug use/abuse
- ☐ anger
- ☐ nervousness
- ☐ sleep
- ☐ relaxation
- ☐ painful thoughts
- ☐ energy (hi/low)
- ☐ legal matters
- ☐ friends
- ☐ compulsivity
- ☐ fetishes
- ☐ impotence
- ☐ loneliness
- ☐ suicidal thoughts
- ☐ education
- ☐ guilt
- ☐ bowel trouble
- ☐ depression
- ☐ divorce
- ☐ alcohol use
- ☐ compulsions
- ☐ self-control
- ☐ ambition
- ☐ spacing out
- ☐ making decisions
- ☐ perfectionism
- ☐ conflict
- ☐ sexual orientation
- ☐ insomnia
- ☐ agoraphobia
- ☐ appetite
- ☐ fears
- ☐ finances
- ☐ confidence
- ☐ unhappiness
- ☐ health problems
- ☐ stress
- ☐ relationships
- ☐ tiredness
- ☐ self-esteem
- ☐ anxiety
- ☐ phobias
- ☐ extreme fatigue
- ☐ panic attacks
- ☐ overweight
- ☐ sexual abuse
- ☐ stomach trouble
- ☐ abused as child
- ☐ short temper
- ☐ work
- ☐ memory
- ☐ my thoughts
- ☐ sadness
- ☐ homicidal
- ☐ eating problem
- ☐ headaches
- ☐ career choices
- ☐ concentration
- ☐ being a parent

Please indicate how the issue(s) for which you are seeking treatment are effecting the following areas of your life:

Marriage / relationship

1 -No effect | 2 - Little effect | 3 - Some effect | 4 - Much effect | 5 - Significant effect | Not Applicable

Family

1 -No effect | 2 - Little effect | 3 - Some effect | 4 - Much effect | 5 - Significant effect | Not Applicable

Job/school performance

1 -No effect | 2 - Little effect | 3 - Some effect | 4 - Much effect | 5 - Significant effect | Not Applicable

Friendships

1 -No effect | 2 - Little effect | 3 - Some effect | 4 - Much effect | 5 - Significant effect | Not Applicable

Financial situation

1 -No effect | 2 - Little effect | 3 - Some effect | 4 - Much effect | 5 - Significant effect | Not Applicable

Physical health

1 -No effect | 2 - Little effect | 3 - Some effect | 4 - Much effect | 5 - Significant effect | Not Applicable

Anxiety level / nerves

1 -No effect | 2 - Little effect | 3 - Some effect | 4 - Much effect | 5 - Significant effect | Not Applicable

Mood

1 -No effect | 2 - Little effect | 3 - Some effect | 4 - Much effect | 5 - Significant effect | Not Applicable

Eating habits

1 -No effect | 2 - Little effect | 3 - Some effect | 4 - Much effect | 5 - Significant effect | Not Applicable

Sleeping habits

1 -No effect | 2 - Little effect | 3 - Some effect | 4 - Much effect | 5 - Significant effect | Not Applicable

Sexual functioning

1 -No effect | 2 - Little effect | 3 - Some effect | 4 - Much effect | 5 - Significant effect | Not Applicable

Alcohol / drug use

1 -No effect | 2 - Little effect | 3 - Some effect | 4 - Much effect | 5 - Significant effect | Not Applicable

Ability to concentrate

1 -No effect | 2 - Little effect | 3 - Some effect | 4 - Much effect | 5 - Significant effect | Not Applicable

Ability to control anger

1 -No effect | 2 - Little effect | 3 - Some effect | 4 - Much effect | 5 - Significant effect | Not Applicable

Substance Use

Do you currently consume alcohol? YES NO

If yes, on average how many drinks per occasion do you consume?

How many days per week do you consume alcohol?

Do you have a history of problematic use of alcohol?

YES NO

Have family members or friends expressed concern about your drinking?

YES NO

Do you currently use non-prescribed drugs or street drugs?

YES NO

Do you have a history of problematic use of prescription or non-prescription drugs?

◯ YES ◯ NO

Do you have a family history of alcohol or drug problems?

◯ YES ◯ NO

If yes, please describe:

Other

Is there anything else that is important for me as your therapist to know about and that you have not written about on any of these forms? Please tell me here; use more paper if needed

Signature: Date: