Jill Racine, PhD
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Client Information (Adult)

Today's Date: _____ Name: _____

Demographic Information

Date of birth: _____ Age: _____ Sex: _____

Home street address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Email: _____

People you live with (names, ages, relationships): _____

_____

_____

Presenting Concerns

What are the difficulties that you brought you here? _____

_____

_____

_____

What do you hope to gain from treatment? _____

_____

_____

_____

Medical Background

Date of last physical exam: _____

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List any medical conditions or allergies you have: _____

_____

_____

List any medications, including dosage and frequency, you are *currently* taking: _____

_____

_____

_____

Education and Employment

Highest grade completed in school: _____ Year: _____ Major: _____

Employer: _____ For how long? _____

Position: _____

Biological Family History

	Name	Any history of mental illness?
Father:	_____	_____
Mother:	_____	_____
Sibling:	_____	_____
Sibling:	_____	_____
Other:	_____	_____

Prior Counseling

List all prior counseling, mental health treatment, or psychiatric hospitalizations: _____

_____

_____

_____

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What was the focus of treatment and what modalities were used (if known)?_____

_____

_____

Was treatment helpful? Why or why not?_____

_____

_____

Other

Is there anything else that would be helpful to know? _____

_____

_____

_____

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Symptom Checklist (Adult)

Please check each item that describes a symptom you have experienced to any significant degree during the last month.

	Physical Symptoms
☐	Alcohol, cigarette, or drug use
☐	Allergies
☐	Appetite change
☐	Backaches
☐	Cold hands and/or feet
☐	Constipation
☐	Diarrhea
☐	Difficulty sleeping
☐	Fatigue, lack of energy
☐	Hair pulling
☐	Headaches [migraine or tension]
☐	Heart beats rapidly, even at rest
☐	High blood pressure
☐	Jaw tension
☐	Muscle cramps, spasms
☐	Nausea
☐	Neck and shoulder pain
☐	Nervous stomach
☐	Skin condition [e.g., rash]
☐	Skin picking
☐	Speech difficulties
☐	Stomach pain or ulcer
☐	Tics
☐	Tight muscles
☐	Tightness or pressure in the head
☐	Weight change

	Psychological Symptoms
☐	Anxiety
☐	Apathy
☐	Compulsive behavior
☐	Confusion
☐	Crying spells
☐	Delusions (false ideas)
☐	Difficulty concentrating
☐	Dissatisfied/unhappy with work
☐	Feeling overwhelmed
☐	Forgetfulness
☐	Frequent irritability/Low frustration
☐	Guilt
☐	Hyperactivity; feeling you can't slow down
☐	Impulsivity
☐	Intrusive, recurrent, unwanted thoughts
☐	Irrational fears
☐	Lack of motivation
☐	Legal difficulties
☐	Loneliness
☐	Low self-esteem
☐	Lying
☐	Mood swings
☐	Nightmares
☐	Relationship/social difficulties
☐	Sadness
☐	Self-harm
☐	Suicidal ideation
☐	Suspiciousness, distrust

Other concerns: _____

_____

_____