

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: _____

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? _____

Symptom Checklist (Adult)

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

Physical Symptoms	Psychological Symptoms
<input type="checkbox"/> Alcohol, cigarette, or drug use	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Allergies	<input type="checkbox"/> Apathy
<input type="checkbox"/> Appetite change	<input type="checkbox"/> Compulsive behavior
<input type="checkbox"/> Backaches	<input type="checkbox"/> Confusion
<input type="checkbox"/> Cold hands and/or feet	<input type="checkbox"/> Crying spells
<input type="checkbox"/> Constipation	<input type="checkbox"/> Delusions (false ideas)
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Difficulty concentrating
<input type="checkbox"/> Difficulty sleeping	<input type="checkbox"/> Dissatisfied/unhappy with work
<input type="checkbox"/> Fatigue, lack of energy	<input type="checkbox"/> Feeling overwhelmed
<input type="checkbox"/> Hair pulling	<input type="checkbox"/> Forgetfulness
<input type="checkbox"/> Headaches [migraine or tension]	<input type="checkbox"/> Frequent irritability/Low frustration
<input type="checkbox"/> Heart beats rapidly, even at rest	<input type="checkbox"/> Guilt
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Hyperactivity; feeling you can't slow down
<input type="checkbox"/> Jaw tension	<input type="checkbox"/> Impulsivity
<input type="checkbox"/> Muscle cramps, spasms	<input type="checkbox"/> Intrusive, recurrent, unwanted thoughts
<input type="checkbox"/> Nausea	<input type="checkbox"/> Irrational fears
<input type="checkbox"/> Neck and shoulder pain	<input type="checkbox"/> Lack of motivation
<input type="checkbox"/> Nervous stomach	<input type="checkbox"/> Legal difficulties
<input type="checkbox"/> Skin condition [e.g., rash]	<input type="checkbox"/> Loneliness
<input type="checkbox"/> Skin picking	<input type="checkbox"/> Low self-esteem
<input type="checkbox"/> Speech difficulties	<input type="checkbox"/> Lying
<input type="checkbox"/> Stomach pain or ulcer	<input type="checkbox"/> Mood swings
<input type="checkbox"/> Tics	<input type="checkbox"/> Nightmares
<input type="checkbox"/> Tight muscles	<input type="checkbox"/> Relationship/social difficulties
<input type="checkbox"/> Tightness or pressure in the head	<input type="checkbox"/> Sadness
<input type="checkbox"/> Weight change	<input type="checkbox"/> Self-harm
	<input type="checkbox"/> Suicidal ideation
	<input type="checkbox"/> Suspiciousness, distrust

Other concerns: _____

