Steve Heymen, PhD

NEW CLIENT INFORMATION Today's date: / /

Your Name: _____ Date of Birth: _____/____/_____

Address_____**Phone**_____

Treatment Goals:_____

_____

_____

Other issues to address in therapy: _____

_____

Please rate the following symptoms on a 1 - 10 scale with 10 being the most or worse level.

- Anxiety rating in the last week_____, highest ever_____, when was that?_____
- Depression rating in the last week_____, worse ever_____, when was that?_____
- Pain rating in the last week_____, most ever_____, when was that?_____
- Stress rating in the last week_____, most ever_____, when was that?_____
- How long have you been challenged with these symptoms?_____
- What is the reason for these symptoms?_____
  _____

CLIENT HISTORY

1. Have you ever received psychological, psychiatric, alcohol or drug treatment before?
   ☐ Yes ☐ No If yes, please indicate:

From Whom? For what? When? With what results?

_____

_____

_____

2. Have you ever been prescribed medications for psychiatric or emotional problems?
   ☐ Yes ☐ No If yes, please indicate:

From Whom? For what? When? Name of Medication With what results?

_____

_____

3. Please list any psychiatric or substance abuse hospitalization/s (include dates of treatment):

_____

_____

4. Do you have a family history of mental illness or substance abuse? If so, please explain.

_____

_____

5. Please provide the name of your primary care physician: _____

_____

Phone Number Address City Zip

May Steve Heymen, PhD contact your primary care physician to coordinate your care?
Yes ☐ No ☐

6. Please list any current medical/health-related conditions, or concerns: _____

_____

7. Please list any current medications (include name of doctor prescribing medication and any over the counter medications or herbal remedies): _____

_____

_____

Other than Prescribed Medications Chemical use:

How many cups of caffeinated coffee, tea, or soft drinks do you drink per day?_____

Do you smoke? ___No ___Quit (date:____) ___Yes (year started_____
What do you smoke and how much per day?_____

Do you drink Alcohol?____No ___Quit (year:____) ____Yes (year started____)
How much per day ?_____

Other non-prescription Drug use: (e.g. pot, hash, speed, coke, crack, LSD, mushrooms, etc not mentioned above? _____
Year started:_____, How much and how often:_____

SYMPTOM CHECKLIST PLEASE CHECK ALL THAT APPLY:

	Headaches		Memory problems		Depression
	Sleep problems		Heart palpitations		Feeling tense or nervous
	Academic concerns		Ideas of harming yourself		Drug use
	Worries about money		Feeling shy around others		Not confident
	Having a lack of friends		Stomach problems		Concerned about eating habits
	Feelings of panic, fear, phobias		Trouble concentrating		Alcohol use
	Feeling sad or depressed		Grief or loss		Nightmares
	Feeling restless		Feelings of hopelessness		Feelings of worthlessness
	Low self-esteem		Disturbing thoughts		Hallucinations
	Aggression		Mood swings		Recurring thoughts
	Chest pain		Suicidal thoughts		Trembling
	Sexual concerns		Sexual identity concerns		Anger
	Ideas of harming others		Gender Identity		Chronic pain
	Blaming or criticizing self		Abusing others		Dizziness
	Feeling tired		Feeling a need to be on the go		Problems at work
	Anxiety		Antisocial or illegal behavior		Concerned about family members
	Irritability		Abused by others		Sick often
	Isolating self		Disorganized thoughts		Relationship problems
	Distractibility		Impulsive		Poor judgment

Please add any other information that would be helpful for the counselor to know.

_____

_____

REFERRAL INFORMATION

Referred by:_____City_____Phone Number_____

May I have permission to thank this person for the referral? ☐ Yes ☐ No