

CLIENT REPORT OF PROBLEM

Name _____ Today's Date _____
 _____ Case # _____

Briefly describe your reason(s) for seeking help:

How long have you had the problem(s)?

Why did you decide to seek help now?

What other ways have you tried to deal with this problem?

History of treatment for emotional problems and family history

| | | |
|--|---------------------------|--------------------------|
| <i>Outpatient treatment</i> | <input type="radio"/> yes | <input type="radio"/> no |
| Did it help? | <input type="radio"/> yes | <input type="radio"/> no |
| Therapist's name _____ | | |
| Dates in treatment _____ | | |
| <i>Inpatient treatment</i> | <input type="radio"/> yes | <input type="radio"/> no |
| Where _____ | | |
| When _____ | | |
| How long _____ | | |
| <i>Family history of emotional problems</i> | <input type="radio"/> yes | <input type="radio"/> no |
| Who _____ | | |

| | | |
|---------------------|--|--|
| Relationship to you | | |
|---------------------|--|--|

Check any of the following items that apply to you:

| | | |
|---|--|---|
| <input type="checkbox"/> Thoughts of suicide | <input type="checkbox"/> Thoughts of harming others | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Trouble getting to sleep | <input type="checkbox"/> History of attempts to kill yourself | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Waking during the night | <input type="checkbox"/> Cutting or otherwise hurting yourself | <input type="checkbox"/> Excessive guilt |
| <input type="checkbox"/> Waking early every day | <input type="checkbox"/> Feelings of hopelessness | <input type="checkbox"/> Forgetfulness |
| <input type="checkbox"/> Financial problems | <input type="checkbox"/> Inability to make decisions | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Trouble controlling your temper | <input type="checkbox"/> Health problems |
| <input type="checkbox"/> Hearing voices | <input type="checkbox"/> Large weight gain or loss | <input type="checkbox"/> Family problems |
| <input type="checkbox"/> Problems at work | <input type="checkbox"/> Seeing things others don't | <input type="checkbox"/> Violence toward others |
| <input type="checkbox"/> Trouble concentrating | <input type="checkbox"/> History of physical abuse | <input type="checkbox"/> Tingling or numbness |
| <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> History of sexual abuse | <input type="checkbox"/> Depressed mood |
| <input type="checkbox"/> Legal problems | | |

(Please complete the other side of this form)

Health Status

List any medical problems or physical problems and when they were diagnosed

1. _____
2. _____
3. _____

List any major (where you were put to sleep) surgeries you have had to date

1. _____
2. _____
3. _____

List any serious illness or injuries especially anything involving the head

1. _____
2. _____
3. _____

List any allergies to foods or drugs

1. _____ 3.
2. _____ 4.

Date of last physical examination _____ Doctor's name _____

May we contact your doctor? yes no

Drug and Alcohol Information

List all of the prescription and over-the-counter drugs you are taking

Check substances you use in any amount at all How much do you use per

| | Age first used | Weekday | Weekend | Month | Last Used |
|---|----------------|---------|---------|-------|-----------|
| <input type="checkbox"/> Beer | | | | | |
| <input type="checkbox"/> Liquor | | | | | |
| <input type="checkbox"/> Wine | | | | | |
| <input type="checkbox"/> Marijuana | | | | | |
| <input type="checkbox"/> Cocaine/Crack | | | | | |
| <input type="checkbox"/> Methamphetamine/Crystal | | | | | |
| <input type="checkbox"/> Heroin | | | | | |
| <input type="checkbox"/> Barbiturates (downers) | | | | | |
| <input type="checkbox"/> PCP, LSD (Hallucinogens) | | | | | |
| <input type="checkbox"/> Tobacco (in any form) | | | | | |
| <input type="checkbox"/> Other _____ | | | | | |

To be completed by adults (18 yrs and older)

| | | |
|---|---------------------------|--------------------------|
| Have you ever felt like you should cut down on your drug or alcohol use? | <input type="radio"/> yes | <input type="radio"/> no |
| Has a friend or relative expressed concerns about your use? | <input type="radio"/> yes | <input type="radio"/> no |
| Have you ever felt guilty about your drinking or drug use? | <input type="radio"/> yes | <input type="radio"/> no |
| Have you ever had to take a drink or use a drug the next day to steady your nerves? | <input type="radio"/> yes | <input type="radio"/> no |
| Are you a recovering alcoholic or a recovering drug addict? | <input type="radio"/> yes | <input type="radio"/> no |
| Is there a history of problems with drug or alcohol use in your family? | <input type="radio"/> yes | <input type="radio"/> no |

To be completed by adolescents (12 yrs to 17 yrs)

| | | |
|---|---------------------------|--------------------------|
| Have you ever used alcohol or drugs before or during school? | <input type="radio"/> yes | <input type="radio"/> no |
| Have you ever missed school (or been truant) because of use or just to use? | <input type="radio"/> yes | <input type="radio"/> no |
| Have you ever avoided non-users? | <input type="radio"/> yes | <input type="radio"/> no |
| How often do you get drunk/high? _____ | | |
| About how often do you use more than one drug when you get high? _____ | | |
| Is there a history of problems with drug or alcohol use in your family? | <input type="radio"/> yes | <input type="radio"/> no |

Therapist Date Client signature Date

[ClientReportOfProblem.PDF](#)