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

Outpatient treatment	o yes	o no
Did it help?	o yes	o no
Therapist's name _____		
Dates in treatment _____		

Inpatient treatment	o yes	o no
Where _____		
When _____		
How long _____		

Family history of emotional problems	o yes	o no
Who _____		

Relationship to you _____		

Check any of the following items that apply to you:

o Thoughts of suicide	o Thoughts of harming others	o Phobias
o Trouble getting to sleep	o History of attempts to kill yourself	o Panic attacks
o Waking during the night	o Cutting or otherwise hurting yourself	o Excessive guilt
o Waking early every day	o Feelings of hopelessness	o Forgetfulness
o Financial problems	o Inability to make decisions	o Mood swings
o Loss of appetite	o Trouble controlling your temper	o Health problems
o Hearing voices	o Large weight gain or loss	o Family problems
o Problems at work	o Seeing things others don’t	o Violence toward others
o Trouble concentrating	o History of physical abuse	o Tingling or numbness
o Racing thoughts	o History of sexual abuse	o Depressed mood
o 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? o yes o 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
o Beer					
o Liquor					
o Wine					
o Marijuana					
o Cocaine/Crack					
o Methamphetamine/Crystal					
o Heroin					
o Barbiturates (downers)					
o PCP, LSD (Hallucinogens)					
o Tobacco (in any form)					
o 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?	o yes	o no
Has a friend or relative expressed concerns about your use?	o yes	o no
Have you ever felt guilty about your drinking or drug use?	o yes	o no
Have you ever had to take a drink or use a drug the next day to steady your nerves?	o yes	o no
Are you a recovering alcoholic or a recovering drug addict?	o yes	o no
Is there a history of problems with drug or alcohol use in your family?	o yes	o no

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

Have you ever used alcohol or drugs before or during school?	o yes	o no
Have you ever missed school (or been truant) because of use or just to use?	o yes	o no
Have you ever avoided non-users?	o yes	o 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?	o yes	o no

_____

_____

Therapist Date Client signature Date

ClientReportOfProblem.PDF