Please circle any of t	he following areas of concern, ei	ther past or present:	
Alcohol/Drug Abuse	Hopelessness	Paranoia	Anger Control
Obsessive Thoughts	Parenting Concerns	Anxiety	Hostility
Phobias	Assertiveness	Isolation	School Problems
Attention/Concentration	Impulse Control Problems	Bereavement/Grief	Self-Defeating Behaviors
Insomnia	Self-Esteem Issues	Communication	Excessive Irritability
Self-Injurious Behaviors	Depression	Identity Issues	Sexual Abuse
Dissociation	Legal Issues	Sexuality	Spirituality
Domestic Violence	Marital /Relationship Problems	Stress	Eating/Food Issues
Medical Concerns	Suicidal Thoughts	Memory	Family Problems
Work Problems	Hallucinations (seeing or hearing things)	Panic Attacks	Excessive Worrying
Sexual Concerns	Delusions (implausible beliefs)	1 dido 1 tituono	Excessive worrying
	,		
Other Concerns:		, 1 5, 1	· · · · · · · · · · · · · · · · · · ·
		Date of Last Visit:_	
	nseling or therapy before? of Problem	Yes No <u>Therapist</u>	Benefit from therapy?
Current medications: Medication I	Dosage Reason for U	se	Prescribing Physician
·			
Please describe use of	alcohol or other substances:		
Substance	Frequency of Use		
Please list anyone in ye		nv or diagnosed with	any type of montal illness.
Relationship to You	our family who has been in thera	P) or anaghosed with	any type of mental mness:
	our family who has been in thera		Notwee of Tour
	our family who has been in thera <u>Problem</u>		Nature of Treatment, if any
			Nature of Treatment, if any
			Nature of Treatment, if any
Is there anything else y			Nature of Treatment, if any
Is there anything else y	<u>Problem</u>		Nature of Treatment, if any
Is there anything else y	<u>Problem</u>		Nature of Treatment, if any