Hope Counseling
CENTER OF SAVANNAH

Note which areas apply with a check and the severity of the symptoms as well as the last time the symptoms occurred.

History of presenting problem(s)/concern(s)	*Yes*	*No*	*Frequency*
a) Problems experienced at home/work/school			
b) Any loss of interest in activities and/or energy			
c) Trouble focusing on a task/project/idea			
d) Sleeping disturbances (restless/insomnia/			
e) Social isolation/withdraw from peers			
Social and/or situational stressors			
a) Conflict within marriage/significant other			
b) History of abuse (physical/sexual)			
c) Financial concerns			
d) Significant losses			
e) Other			
Mood disturbance			
a) History of depression			
b) Crying spells			
c) Changes in eating habits			
d) Amount of weight gained or lost			
e) Irritability/outbursts			
f) Suicidal thoughts/gestures/plan/attempts			
Anxiety			
a) History of anxiety diagnosis			
b) Anxious			
c) Phobia			
d) Worrisome behaviors			
e) Panic attacks			
f) Obsessive/compulsive behaviors			
ADHD			
a) History of ADHD diagnosis			
b) Impulsiveness			
c) Easily distracted			
d) Academic difficulties			
Autism			
a) History of Autism diagnosis			
b) Developmental concerns			
c) Poor social skills			

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Previous Medical History:

Allergies:_____

Primary Care Physician's Name and Phone #:_____

Date of the last Physical Exam:_____

Results of the Exam:_____

Revelant Medical Conditions:_____

Current Medications:_____

Recent and Past Hospitaliztions and Surgeries:_____

Past Psychiatric History

Hospitalizations:_____

Prior Outpatient Therapy:_____

Prior Inpatient Therapy:_____

Previous Clinicans and date of services:_____

Prior response to Treatment including medications:_____

Mental Health History of Family Members:_____

Substance Abuse History of Family Members:_____

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Family Members Residing in the Household

Name:	Age:	Sex:	Relationship:

Signature: Date:

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