Additional Participant's Name: _____ I.D. # _____

Previous counseling? Yes No

Provider _____
Date_____
Duration_____

Why seen? _____

Was it helpful? Yes No

Why? _____

Do you have any health care problems (including allergies)? _____
_____
_____

Are you on any Rx? Yes No If yes, please list (dosage/frequency/duration)

1. _____ 2. _____
3. _____ 4. _____

Last Doctor's visit _____ Doctor's name _____

Why were you seen? _____

Any past hospitalizations (date and reasons): _____
_____

Religious Background? _____

Have you ever felt guilty about your drinking/drugging? Yes No
Have you ever felt annoyed by people criticizing it? Yes No
Have you ever thought you should cut it back? Yes No
Have you ever had a morning eye opener to relieve a hangover? Yes No

ADDITIONAL PARTICIPANT: Please check the box if you are PRESENTLY experiencing any of the symptoms below.
Please add a star (*) next to those that have been going on a long time.
(9 months or more for adults, 3 months or more for children)

- ☐ Trouble concentrating
- ☐ Nervousness
- ☐ Excessive worrying
- ☐ Thought and speech mixed up
- ☐ Anxiety
- ☐ Uneasy in crowds
- ☐ Mind going blank
- ☐ Impulse to repeat absurd behaviors
- ☐ Feeling panicky
- ☐ Scared for no reason
- ☐ Fearful
- ☐ Avoiding places because they are frightening

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- ☐ Awakening at night or earlier that usual
- ☐ Unable to have a good time
- ☐ Recent weight loss
- ☐ Having no interest in things
- ☐ Tired most of the time
- ☐ Depression
- ☐ Crying more often than usual
- ☐ Feelings of hopelessness
- ☐ Feeling worthless

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- ☐ Feeling others are to blame
- ☐ Feeling most people cannot be trusted
- ☐ Others not giving proper credit for your work
- ☐ Others taking advantage if you let them
- ☐ Having ideas or beliefs that others do not share
- □ Being watched or talked about

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- ☐ Feeling weak in parts of you body
- ☐ Fast heartbeat
- ☐ Trouble with vision or hearing
- ☐ Headaches
- ☐ Dizziness or faintness
- ☐ Poor appetite
- ☐ Change of sensation in parts of your body
- ☐ Tremors
- ☐ Feeling a lump in your throat
- ☐ Nausea or upset stomach
- ☐ Trouble getting your breath
- ☐ Hot or cold spells

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- ☐ Bothered by unusual odors
- ☐ Feeling things are unusual
- ☐ Never feeling close to another person
- ☐ Having thoughts that are not your own
- ☐ Hearing voices that others do not hear
- ☐ Having strange and peculiar experiences
- ☐ Traveling somewhere without knowing how you got there
- ☐ Feeling something is wrong with your mind
- ☐ Seeing things that other do not see

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- ☐ Urges to smash things
- ☐ Restlessness
- ☐ Temper outbursts
- ☐ Feelings of "wanting to end it all"
- ☐ Urges to harm someone
- ☐ Easily irritated
- ☐ Controlling your impulse
- ☐ Having made a suicide attempt
- ☐ Being "on top of the world" for no reason
- ☐ "losing it"
- ☐ Being a hothead
- □ Wanting to hurt yourself

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- ☐ Financial problems
- ☐ Unable to find/ keep a job
- ☐ Using drugs
- ☐ Difficulty reading
- ☐ Difficulty in school
- ☐ Legal problems
- ☐ Having an unwanted habit
- ☐ Unhappy with present occupation
- ☐ Using alcohol
- ☐ (Create your own:)

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- ☐ Getting along with others
- ☐ Home conditions bad
- ☐ Socializing
- ☐ Feeling inferior to others
- ☐ Making decisions
- ☐ Communicating
- ☐ worried about sex matters
- ☐ having been abused
- ☐ feelings being easily hurt