Inner Source
Psychotherapy & Consultation Services

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MEDICAL HISTORY & GOALS FOR THERAPY

PLEASE PRINT CLEARLY

BRIEF OVERVIEW OF MEDICAL HISTORY AND CURRENT CONDITIONS

Today's Date: _____

Client Name _____**DOB**_____

Primary Physician _____

Clinic Name _____City_____

Phone Number _____Fax Number_____

1. I would describe my current health status as: (Circle one)

Excellent Good Fair Poor

2. Please list any current medical conditions or concerns:

_____

_____

_____

3. Are you currently under the care of a physician (or more than one practitioner)?

_____

_____

4. Have you been hospitalized or had a serious illness within the past two years?

If so, please explain: _____

_____

_____

5. Are you presently taking any medication for medical or psychological conditions?

Please list: _____

_____

_____

6. Have you ever attempted suicide? If so, how long ago and did you go to a hospital?

_____

_____

7: Please list any alternative treatments, practitioners and supplements used currently.

_____

_____

8. Are there any other medical issues or concerns that you would like to tell me about?

_____

Checklist of Concerns

Please check any present concerns or significant past concerns that still affect you:

__Anger	__Health	__Bipolar illness	__Gender Identity
__Abuse	__Trauma	__Aggression	__Separation/Divorce
__Self-esteem	__Depression	__Codependence	__Impulsiveness
__Relationships	__Anxiety	__Alcohol/Subs Ab.	__Work/Career
__Communication	__Panic attacks	__Sexual Orient.	__Family relations

__ Other: (please list) _____

_____

_____

Goals for Therapy

If you could get what you want from therapy, what would that be?

1) _____

2) _____

3) _____

4) _____

Client Name _____DOB_____

Symptom Checklist

Smoking

Have you ever smoked? Y N Never

If yes, do you wish to quit? Y N

Depression Symptoms

__ Depressed Mood most days for at least 2 weeks

__Markedly diminished pleasure and interest in most activities you usually enjoy

__Difficulties with focus and concentration

__Significant decrease or increase in appetite

__Significant decrease or increase in sleep, or increased difficulty falling or remaining asleep

__Extreme agitation, restlessness and/or lethargy, feeling "slowed down" beyond usual for you

__Fatigue or loss of energy nearly every day

__Feelings of worthlessness, excessive or inappropriate guilt nearly every day

__Diminished ability to think or concentrate, or extreme indecisiveness

__Recurrent thoughts of death, __ recurrent suicidal ideation (no specific plan) or __suicide plan/intent

Anxiety Symptoms

__Fear or anxiety about using public transportation, being in open spaces, crowds, or away from home

__Excessive anxiety and worry about a number of things for over 6 months

__The anxiety and worry are hard for you to control

__Feeling keyed up, on edge, irritable, easily fatigued, muscle tension, mind going blank, foggy thinking

__Fear of social situations and interactions with people in a variety of circumstances

Pain Rating Scale

__Average level of pain (beyond normal aches or soreness) experienced on a regular basis (circle number)

None 0 1 2 3 4 5 6 7 8 9 10 Extreme pain

__Are you working with physician or pain specialist for treatment of pain: Yes No

__Is your pain under adequate control with your present medical treatment? Yes No

__Type/location of chronic pain: _____

_____

Other Symptoms of Concern (please list)

1) _____

2) _____

3) _____

4) _____

5) _____