Capital District Behavioral Health, PLLC

Name:_____ Occupation:_____ Age: _____ Date: _____

How did you hear about our practice? _____

What are the main reasons you are seeking treatment at this time?

_____

_____

Have you ever had psychological or psychiatric treatment in the past? If yes, when, with whom and for how many sessions?

_____

_____

Please check any of the following symptoms that have been a problem for you recently:

____ Anger	____ Overeating	____ Aggression
____ Anxiety	____ Weight Loss	____ Confusion
____ Headaches	____ Poor Concentration	____ Depression
____ Illogical Ideas	____ Low Energy	____ Guilt
____ Abdominal Pain	____ Low Self-Esteem	____ Grief
____ Chronic Pain	____ Memory Problems	____ Hostility
____ Sexual Problems	____ Lack of Motivation	____ Irritability
____ Sleep Problems	____ Worry	____ Phobic
____ Mind Races	____ Panic Attacks	____ Gastrointestinal
____ Palpitations		

Other Symptoms or issues:_____

Briefly explain how these problems or symptoms have been affecting your life, including relationships, home and job functioning etc.:

_____

_____

_____

Which areas of your life have been stressful recently? (please check all that apply)

____ Family /Friends ____ Health ____ Finances ____ Job / School ____ Legal Problems

How severe has your stress level been lately? ____ Mild ____ Moderate ____ Severe

Have you been treated for substance abuse? ____ Yes _____ No

What goals would you like to accomplish in therapy?

_____

_____

**** PLEASE COMPLETE THE MEDICAL HISTORY ON THE BACK OF THIS FORM****

Medical History

Who is your Primary Care Physician? _____

Office Address: _____

Office Phone: _____

Date of last exam?: _____

Please list any known allergies: _____

Please list current medications, with dosage if known:

Medication:	Dose:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any MAJOR injuries or surgeries you have had:

_____
_____
_____
_____
_____

Briefly describe any physical issues that are currently affecting your life:

_____
_____
_____
_____
_____
_____

THANK YOU