CLIENT REPORT OF PROBLEM

Name ______________________________ **Today's Date** ___________ **Case #** ___________

Briefly describe your reason(s) for seeking help

How long have you had the problem(s)?

Why did you decide to seek help now?

What other ways have you tried to deal with this problem?

History of treatment for emotional problems and family history

Outpatient treatment ☐ yes ☐ no
Did it help ☐ yes ☐ no

Therapist's name ______________________________
Dates in treatment ______________

Inpatient treatment ☐ yes ☐ no
Where ______________________________________
When ______________________________________
How long ____________________________________

Family history of emotional problems ☐ yes ☐ no
Who ____
Relationship to you ______________________________

Check any of the following items that apply to you:

- ☐ Thoughts of suicide
- ☐ Trouble getting to sleep
- ☐ Waking during the night
- ☐ Waking early every day
- ☐ Financial problems
- ☐ Loss of appetite
- ☐ Hearing voices
- ☐ Problems at work
- ☐ Trouble concentrating
- ☐ Racing thoughts
- ☐ Legal problems
- ☐ Thoughts of harming others
- ☐ History of attempts to kill yourself
- ☐ Cutting or otherwise hurting yourself
- ☐ Feelings of hopelessness
- ☐ Inability to make decisions
- ☐ Trouble controlling your temper
- ☐ Large weight gain or loss
- ☐ Seeing things others don't
- ☐ History of physical abuse
- ☐ History of sexual abuse
- ☐ Phobias
- ☐ Panic attacks
- ☐ Excessive quilt
- ☐ Forgetfulness
- ☐ Mood swings
- ☐ Health problems
- ☐ Family problems
- ☐ Violence toward others
- ☐ Tingling or numbness
- ☐ Depressed mood

(Please complete the other side of this form)