TVC

1811 B Green Circle
Valdosta, GA 31602
229-244-9688

Name:_____ Date:_____

Do you have any problems at this time?_____
_____

Please check any symptoms that describe how you feel, think, or behave currently or during the past few weeks:

( ) Abdominal pain
( ) Agitation
( ) Avoidance of public places
( ) Change in ability to walk
( ) Chest tightness
( ) Confused/worried about sexual behavior
( ) Crying episodes
( ) Difficulty at work
( ) Difficulty concentrating
( ) Difficulty functioning socially
( ) Difficulty waiting your turn
( ) Easily startled
( ) Excessive spending
( ) Fainting
( ) Fear of leaving home
( ) Fearfulness
( ) Frustration
( ) Hopelessness
( ) Irritability
( ) Loss of appetite
( ) Marital conflict
( ) Multiple sexual partners
( ) Muscle weakness
( ) Neck pain
( ) Aggressive/abusive towards others
( ) Attempts to harm self
( ) Back pain
( ) Chest pain
( ) Chronic sadness
( ) Constipation
( ) Diarrhea
( ) Difficulty completing tasks
( ) Difficulty focusing
( ) Difficulty making decisions
( ) Dizziness
( ) Excessive gambling
( ) Excessive worry
( ) Fear of dying
( ) Fear of loss of control
( ) Frequent forgetfulness
( ) Hard to stay with job very long
( ) Intrusive thoughts of bad memories
( ) Legal problems
( ) Low energy/fatigue
( ) Memory problems
( ) Muscle stiffness
( ) Nausea/vomiting
( ) Nightmares

( ) Not well organized
( ) Panic attacks
( ) Pounding heart/palpitations
( ) Racing thoughts
( ) Re-living bad experiences
( ) School problems
( ) Seizures
( ) Shortness of breath
( ) Snoring
( ) Taking on too many tasks
( ) Thoughts of physically hurting others
( ) Trembling/shaking
( ) Withdraw from others
( ) Overeating
( ) Physical abuse
( ) Problems with co-workers
( ) Reduced interest in activities
( ) Restlessness
( ) Seeing things others don't
( ) Sexual abuse
( ) Sleep problems
( ) Staying up for days without sleep
( ) Tendency to act impulsively
( ) Thoughts of suicide
( ) Vision changes

Please describe why you are seeking help at this time_____
_____

Has any member of your family been hospitalized for mental health concerns?_____
If yes, please list who, when and for what reason: _____

_____

_____

Do/did you have any family members who have/had problems with drinking alcohol or using drugs?____
If yes, please list who, when and if it is still a problem:_____

_____

_____

Has any member of your family attempted/committed suicide?_____
If yes, please list who, when, and what happened:_____

_____

_____

What is your **best** memory about your family when growing up?_____

_____

If you could change anything about your family situation right now, what would it be?_____

_____

Have you ever seen a counselor, psychologist, psychiatrist, or other mental health professional for any mental health or drug/alcohol concerns?_____
If yes, please list who, when and why:_____

_____

Have you ever been hospitalized for mental health or drug/alcohol concerns?_____
If yes, please list when and for what reason:_____

_____

Do you have thoughts of harming yourself?_____ If so, how often does this happen?_____

Have you ever tried to harm yourself?_____ If so, when did this happen?_____

Did you receive medical help at the time?_____

Current Medications

(Please include prescription, over the counter, herbs, vitamins, and other remedies)

Medication	Dosage/when taken	Reason taking	Prescribing Doctor

Allergies to medications:_____

_____

Please list any current medical problems or concerns:_____

_____

_____

Please list any past serious illnesses, surgeries or health concerns:_____

_____

_____

Exercise and Physical Recreational Activity

Type of activity How often

_____

_____

_____

Would describe yourself as physically active?_____

Do you currently have a primary care physician? If so, please list his/her name:

_____

Are you currently under the care of any other physicians? If so, please list names:

_____

_____

_____

Use of substances (on average)
If none, please leave blank.

	Current amount	Most used in past
Alcohol	_____ glasses per day _____ glasses per week	_____ glasses per day _____ glasses per week
Tobacco	___cigarettes _____ per day ___ cigars _____ per day __ smokeless ____ cans per day	___cigarettes _____ per day ___ cigars _____ per day ___ smokeless ___ cans per day
Caffeine (tea, coffee, soda)	_____ servings per day	_____ servings per day
Marijuana	_____ per day _____ per week	_____ per day _____ per week
Cocaine	_____ times per day _____ times per week	_____ times per day _____ times per week
Diet pills **Name:_____**	_____ pills/doses per day _____ pills/doses per week	_____ pills/doses per day _____ pills/doses per week

Marital status:_____Children:_____
Education:_____Living arrangements:_____
Employment:_____
Military service:_____