Name:____ Date of Birth: ________

Home Address: ____

Mailing Address: ____

Home Phone: _________________ Mobile Phone: _____________ __

e-mail: ________________________________ Marital Status: _________

Employment: ____

Work Phone: _______________________

Insurance #1:__________________________ Policy #: ___________________

Name of Insured: ____

Relationship to Client: ________________

Additional Insurance: ______________________ Policy #: __________________

Name of Insured: ____

Relationship to Client: ________________

Emergency Contact: ____

Relationship to client: __________________________________

Address: ____

Phone Numbers: ____

e-mail: ____

Please check off symptoms that you have experienced in the past two weeks:

___ Depressed mood most days

___ Irritable mood most days

___ Euphoria ("on top of the world") most days

___ Worry or anxiety most days

___ Feelings of guilt or worthlessness

___ Crying most days

___ Verbal anger outbursts

___ Physical aggression outbursts

___ Loss of interest in enjoyable things

___ Low energy

___ Excessively high energy

___ Loss of concentration/attention

___ Difficulty with memory

___ Finding tasks more difficult to perform

___ Insomania (sleeping too little)

___ Hypersomnia (sleeping too much)

___ Loss of appetite

___ Eating more than usual

___ Significant weight gain/loss

___ Thoughts of harming yourself

___ Thoughts of harming others

___ Self-harm (cutting, burning)

___ Suicide plan or attempt

___ Racing thoughts

___ Speaking faster than usual

___ Feelings of impending doom

___ Increased heart rate

___ Shortness of breath

___ Panic

___ Stiff muscles

___ Excessive headaches

___ Chronic pain

___ Isolating (avoiding people or places)

___ Nightmares

___ Flashbacks

___ Easily startled

___ Thoughts that won't go away

___ Compulsions (repetitive rituals)

___ Other distressing symptoms: ____