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Licensed Psychologist 912 W Platt ST, S. 101, Tampa, FL 33606 & 3000 Gulf to Bay Blvd S. 310 Clearwater, FL 33759

Client Information

_____ • M • F ___/____/_____ _____ ____/___/2020
Last Name First Name MI Sex Date of Birth Age Today's Date

_____ (_____)_____-_____
Address City State Zip Mobile Phone

Permission to: Mail to this address? • Yes • No Text this number ? • Yes • No **EMAIL:** _____

_____ _____ _____ • (____)_____
Occupation Place of Employment or Unemployed Time Employed there Work Phone

_____ • Yes • No _____
Highest Level of Education Reached/ Degree Currently a Student? Current School

_____ _____(____)_____
Primary Physician Phone Emergency Contact Relationship Phone #(s)

_____ _____
Referred by Reason for Visit / Primary Concern

Family Information

Please provide information about members of immediate family, i.e., spouse/partner, children, parents, and siblings:

Name	Relationship	Age if Living	Occupation or School Grade

Health Information

Do you have health issues that currently concern you? • Yes • No If yes, please describe below:

_____

Have you received treatment / Are you currently receiving medical treatment? • Yes • No If yes, please describe below:

_____

Are you presently taking medication? • Yes • No If yes, please list below:

_____

Have you seen this type of therapist/psychologist/psychiatrist before? • Yes • No If yes, list when and with whom:

From - To	Treated by	Type of Treatment
_____ - _____	_____	_____
_____ - _____	_____	_____

(Please Complete Back of Questionnaire)

Symptom Questionnaire

Never	Almost Never	Sometimes	Almost Always	Always
1	2	3	4	5

Please use the scale ABOVE to respond to the following questions:

____ I easily fall to sleep at night
____ I sleep more than 8 hours each night
____ I worry too much
____ I have difficulties being social
____ I have suffered a loss/trauma
____ People annoys me
____ I worry about what others think of me
____ My friends and family say I am acting differently
____ At night or at other times I cannot turn off my thoughts
____ I wake up during the night or before I had planned to awaken
____ I find myself replaying conversations over and over in my mind
____ I do not feel like myself
____ I have been told that I have lots of energy
____ I drink beer, wine, and/or hard liquor
____ I trust others
____ My eating patterns are irregular
____ I use less drugs than my doctors prescribe
____ I use more drugs than my doctors prescribed

Using the same scale, please rate *feelings, behaviors,* ***or*** *issues* **you are having (<u>Rate what applies</u>):**

____ Anger
____ Forgetful
____ Annoyed
____ Guilty
____ Sad
____ Happy
____ Confused
____ Conflicted
____ Optimistic
____ Disappointed
____ Anxious
____ Shameful
____ Motivated
____ Fearful
____ Regretful
____ Fatigued
____ Panicky
____ Hopeless
____ Tense
____ Enthusiastic
____ Jealous
____ Lonely
____ Relaxed
____ Fear of others
____ Fear of Abandonment
____ Fear of Nightmares
____ Loss of Meaning/Purpose
____ Feel like a burden on others
____ Muscle Aches
____ Overly Energetic
____ Digestive Issues
____ Pain/discomfort
____ Headaches
____ Moodiness
____ Sexual dysfunction
____ Sexual disinterest
____ Laziness
____ Crying spells
____ Temper outbursts
____ Easily irritated
____ Suicide thoughts
____ Suicide attempts
____ Self-injury
____ Binging/purging
____ Missing work
____ Withdrawal/Isolating
____ Flashbacks
____ Trust issues
____ Sleep disturbance
____ Over spending
____ Working too much
____ No Assertiveness
____ Odd Behaviors
____ Difficulties concentrating
____ Risk-taking behaviors
____ Other impulsive/compulsive behavior: _____

Losses/Traumas you suffered: _____ **Year:**_____**;** _____**Year:** _____

_____**Year:**_____**;** _____ **Year**:_____; _____**Year:**_____

OTHER PROBLEMS I am experiencing include:

_____

My HOPE is that my THERAPY will lead to:

_____

_____