

TVC

2310 N. Patterson St. Ste-G

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:

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

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

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
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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: _____