Psychological & Counseling Associates, P.C.

Dr. Belvia W. Matthews ♦ Dr. Calvin O. Matthews

Patient Name:____________________________________Date: ________________

Please read the following questions and answer to the best of your ability by placing a checkmark in the appropriate boxes or fill in the blank as directed. Your cooperation is appreciated.

Referred by: ____

Please state in your own words why you have come to this office today:

____

____

What is it you want to gain by coming here?

____

____

Please check ALL of the following symptoms or thoughts that apply to you **<u>AT THIS TIME or during the past six months:</u>**

___Depressed mood
___Diminished interests or pleasure
___Sleep disturbance
___Fatigue
___Change in appetite
___Hopelessness
___Pleasure in few activities
___Weight change
___Agitation
___Excessive worry
___I feel like I am losing control.
___Irritability
___Poor Concentration
___Tension
___Feelings of panic
___Socially withdrawn
___Use of alcohol
___Use of other drugs
___Use of tobacco
___Anxiety in social settings
___Makes careless mistakes
___Does not complete tasks
___Difficulty organizing
___Forgetful
___Confusion
___Disorientation

___Compulsive checking / counting
___Indecisiveness
___People talk about me.
___Some people want to hurt me.
___I feel emotionally distant from others.
___I hear voices or sounds others do not hear.
___I see things others do not see.
___I smell things others do not smell.
___Racing thoughts
___I do risky or dangerous things.
___Little interest in sexual activity
___Sexual problems
___Gender concerns
_ I don't like my body.
___Binge eating
___Self-induced vomiting
___Laxative abuse
___Excessive fasting
___Intense fear of weight gain
___Impulsive
___I think about hurting myself.
___I have tried to hurt myself.
___Sometimes I wish I were dead.
___I think about hurting someone else.
___Exposed to a significant traumatic event
___Recurrent distressing dreams

Psychiatric History:

I have received treatment for: □Substance abuse □Mental health issues □Both

The treatment occurred at:

□ Private psychiatrist □ Private counselor/therapist □ Mental Health Center
□ Hospital □ Other facility

Are you presently being treated? □Yes □No If yes, by whom? ____________
____

Medical History:

Your current weight___________Height in inches __________

Name of your primary care doctor ______________________________________

Phone: _____________________________ Date last seen: _______________________

Do you have a history of any medical problems? □Yes □ No If so, what?
____

Are you presently being treated for any medical problem? □Yes □No If so, what?
____

____

Past surgeries: ____
____

____

Date of last menstrual cycle:__________________________

What form of birth control do you use?__________________

Have you ever been treated for a nutritional problem? (If yes, complete following questions)	□ Yes	□ No
Do you make yourself sick because you feel uncomfortably full?	□ Yes	□ No
Do you worry you have lost control over how much you eat?	□ Yes	□ No
Have you recently lost more than 14 pounds in a 3 month period?	□ Yes	□ No
Do you believe yourself to be fat when others say you are too thin?	□ Yes	□ No
Would you say that food dominates your life?	□ Yes	□ No

Are you experiencing any physical pain? Yes____No ____

Have you ever received treatment for any of the following medical conditions?

___Neurological impairment
___Seizure disorder
___Visual loss / impairment
___Hearing loss / impairment
___Dementia
___GI disorder
___Obesity
___Significantly underweight
___Cirrhosis
___Hepatitis
___Heart condition
___Hypertension
___Asthma
___Emphysema
___Chronic bronchitis
___Tuberculosis / +PPD
____Cancer
____Thyroid disease
____Diabetes
____Pregnancy
____Irregular menstrual periods
____Musculoskeletal condition
____HIV / AIDS / Related condition
____Other

Please list any medications you are presently prescribed.

____
____
____
____

What are you leisure activities/interests? ____

What do you do for exercise/recreation? ____

Do you have sleep difficulties? □Yes □No If yes, please explain
____

Energy level: □Sufficient to do what you want to do □ Tired most of the time

Average number of cups/glasses of caffeine consumed daily: Coffee___Tea___Soft Drinks___

Cigarette Smoking: □Never □Quit Years smoked ____ Packs/day ____

Alcohol Usage: □Never □Less than 1/month □1-4 times/month □2-3 times/week □Daily

Alcohol-related problems: □Binges □Hangovers □Job Problems □Assault □Arrests □Interpersonal Problems □Concern over drinking □Medical complications

Substance Abuse: □Marijuana □Sedative □Stimulant □Cocaine □Opiates □Inhalants

Thank you for your cooperation and patience. Your clinician will see you shortly and discuss these and other issues in greater detail and help you develop a treatment plan to effectively deal with these issues.