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Please take a few minute to complete this form so that I can know you better. If you do not feel comfortable completing any part of this, please let me know. Thank you.

Name: _____ **Today's Date** _____

Please check off only the symptoms you have had in the last two months:

Mild	Moderate	Severe		Mild	Moderate	Severe	
___	___	___	Low energy/fatigue	___	___	___	Difficulty speaking
___	___	___	Impulsivity	___	___	___	Diminished ability to think
___	___	___	Moving very slowly	___	___	___	Distractibility
___	___	___	Restlessness	___	___	___	Indecisiveness
___	___	___	Trouble going to school/work	___	___	___	Memory impairment
___	___	___	Behaving with aggression/rage	___	___	___	Flight of ideas
___	___	___	Compulsions	___	___	___	More talkative than usual
___	___	___	Deceitfulness/theft	___	___	___	Pressured speech
___	___	___	Destructive	___	___	___	Racing thoughts
___	___	___	Disorganized	___	___	___	Poor attention or concentration
___	___	___	Reckless	___	___	___	Disturbance in body perception
___	___	___	Self-injurious	___	___	___	Hallucinations
___	___	___	Social withdrawal	___	___	___	Obsessions
___	___	___	Violation of rules or others' rights	___	___	___	Paranoid thoughts
___	___	___	Anxiety/fearful	___	___	___	Recurrent thoughts of distressing events
___	___	___	Interpersonal rejection sensitivity	___	___	___	Suicidal thoughts
___	___	___	Jitteriness	___	___	___	Binge eating
___	___	___	Panic attacks	___	___	___	Decreased appetite
___	___	___	Phobia(s)	___	___	___	Increased appetite
___	___	___	Worrying	___	___	___	Change in weight + 5lbs
___	___	___	Feeling anger	___	___	___	Self-induced vomiting
___	___	___	Not caring any more	___	___	___	Excessive exercising
___	___	___	Feeling numb	___	___	___	Excessive use of laxatives
___	___	___	Depressed mood	___	___	___	Excessive or inappropriate guilt
___	___	___	Helplessness	___	___	___	Feeling worthless
___	___	___	Hopelessness	___	___	___	Tearfulness
___	___	___	Irritability	___	___	___	Loss of interest/pleasure
___	___	___	Low self-esteem	___	___	___	Marked mood shifts
			SLEEP DISTURBANCE:	___	___	___	Early morning awakening
				___	___	___	Sleeping extra/hypersomnia
				___	___	___	Trouble going to sleep
				___	___	___	Awakening during the night

Physical symptoms during the last three months: Please answer yes (y), no (n), or unsure (u)

___	headaches	___	abdominal pain	___	trouble swallowing
___	dry mouth	___	nausea	___	fainting or loss of consciousness
___	vomiting	___	seizure or convulsion	___	bloating (gassy)
___	trouble walking	___	diarrhea	___	get sick on several different foods
___	joint pain	___	pain in hands or feet	___	pain in genitals other than during sex
___	pain urinating	___	other pain	___	shortness of breath when not exerting self

___ palpitations ___ chest pain ___ dizziness
___ loss of voice ___ deafness ___ double vision
___ blurred vision ___ blindness ___ trouble walking
___ paralysis or muscle weakness ___ urinary retention or difficulty ___ long periods w/no sexual desire
___ other serious physical symptoms for which doctors could find no explanation

Other medical problems/information:

Have you ever had recurrent thoughts of death or attempted suicide? Yes _____ No _____

Have you ever:
Taken an overdose?

Slashed or cut your wrists or other parts of the body? _____
Inflicted cigarette burns or other self injuries? _____
Used a gun, knife or other weapon on yourself or others? _____
Attempted hanging? _____
Used another method to hurt yourself? _____

Please describe your current problem:

What made you decide to get help at this time? _____

Physicians' names and dates of last visits (approx):

Has anyone in your family been treated for mental illness?

Employment history/current employment:

Educational Background:

What do you hope will change for you by coming to counseling?

Signature: _____

Date: _____
