Date: _____

Parker, Schlichter & Associates
& Hope Christian Counseling

Client Medical Information

Client Name: _____ DOB: _____

Primary Care Physician

Name: _____ Phone # _____

Previous Psychiatrist (If Applicable)

Name: _____ Phone#_____

List any health problems for which you have recently received or are currently receiving treatment:
_____
_____

List any medical or psychiatric hospitalizations and dates:
_____
_____

List any psychiatrist or therapist that you have seen or are currently seeing: _____
_____

History of significant illness or injury:
_____
_____
_____

List all medications you are currently taking (Over the counter and Prescription):
_____ _____
_____ _____

List previous Psychiatric/ADHD medications tried, dates tried and Reason(s) for discontinuation:

Medication:	Dates:	Reason:
_____	___/___/___ to ___/___/____	_____
_____	___/___/___ to ___/___/____	_____
_____	___/___/___ to ___/___/____	_____

Any Allergies? _____

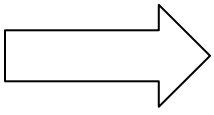
History of head trauma (Circle one) YES (If yes, Please explain) NO

_____

Are you pregnant? YES NO

History of tobacco use (please circle all that apply): cigarettes cigars pipe chewing other
Are you **currently** using any of the above items that you circled? YES NO

Please turn over to complete back



Client Name **Date**

PARKER, SCHLICHTER AND ASSOCIATES
HOPE CHRISTIAN COUNSELING

Symptom Checklist

Unhappiness Depressed mood Frequent crying/tearfulness Low energy Difficulty concentrating Indecisiveness Hopelessness Worthlessness Poor appetite Overeating Sleeping too much Unable to go to sleep Unable to stay asleep Lack of interest/pleasure in activities (including sex) Loneliness	Often interrupts others Difficulty sustaining attention Procrastination Easily distracted Impulsivity Inability to concentrate Unable to be still Inability to focus Difficulty organizing Starts but doesn't finish task Indecisiveness Bedwetting Fire setting Stealing Physical fights
Suicidal thoughts Suicidal attempts Homicidal thoughts Homicidal attempts Self-destructive behavior including cutting, burning oneself	Argumentative Destruction of property Nightmares Obsessive thoughts Withdrawal from friendships Decrease in socialization
Excessive worrying Fearful of _____ Panic attacks Racing/pounding heart Hot flushes Shortness of breath Trembling Headaches Stomachaches Feeling like you are going crazy	Hypervigilence Easily startled Memory problems Flashbacks Intrusive memories Numbness Inability to have loving feelings Feeling detached from oneself Compulsive behavior Poor impulse control
Racing thoughts Agitation Decreased need to sleep Outbursts of anger Feeling on top of the world Increased energy Poor judgment Sexual indiscretions Bad business ventures Buying sprees Activities with potential for harm Not doing homework or assigned tasks Late for school or work	Difficulty with any of the following: Caring for children Cleaning the house Cooking meals Driving the car Running errands Functioning at work Functioning at school Performing personal hygiene/dressing self Eating properly Taking medications as prescribed Exercising Getting out bed