Date	Pt. Name	Pt. DOB	Insurance Co.	Pharmacy Tel

Any **Health Insurance** related changes since pt's last visit?		**PROVIDER USE ONLY**
Are you or family member involved in any **court case**?		
Describe pt's **sleep**; include if there is trouble falling asleep or waking up a lot at night. Any scary **dreams**?		
How is pt's **appetite**?		
Any changes in pt's **weight**?		
How is pt's **energy/activity** level?		
How has pt's **mood** been?		
Any **crying** or **withdrawing** from others?		
Have you had any **thoughts** of **harming yourself**?		
Do you have any **plans** to **harm yourself**?		
Have you **tried** to **harm yourself** recently?		
How do you **cope** with thoughts of **hurting** / **harming** yourself?		
Has pt been **aggressive**: • **verbally** • physically to **people** • to **property**		
Has pt thought of **running** away?		
Any scary or angry **inner voices** or **visions**?		
Any evidence of **agitation**?		
Any **panic attacks** or anxiety (heart beat fast, stomach churn, marked anxiety or nervousness?		
Any **fear of being out** in car, in store, or in presence of others, or in crowds?		
Any rituals, **obsessions, or compulsive urges** or behaviors?		

Any urges to **steal**, **gamble**, **spend**, **fire-set**?		**PROVIDER USE ONLY**
Any **memory problems**?		
Any **confusion spells**?		
Circle & Describe other significant details including: - **Medication** Changes - **Emergency** Visit to ER/Doctor - New **Stresses** - Overall **progress** or **worsening** of symptoms - **Changes** in **school, work, home, family, relationships, peer,** etc. - General Symptoms - Aches, pain, muscle stiffness, etc. - Eyes - ENT - Cardiovascular – Palpitations, etc - Respiratory - Gastrointestinal - Genitourinary - Muscular - Integumentry - Neurological - Endocrine - Hemotologic - Allergies		
Any **side-effects** from psychiatric medications?		
Are you using **alcohol** or any illicit **drugs**?		
What have you been working with your **therapist** on?		
Questions you may like to ask the doctor about **medicines**?		
Other concerns you may have?		

PROVIDER USE ONLY For additional information, see typed note.

Pt. Signature_____Clinician's Initial_____ Date _____