Keystone

Client's Name: _____ Date Completed: _____

Reason for Seeking Treatment: _____

_____

Rate Intensity of Presenting Problem: (None) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Most)

Client Information: Please mark appropriate box and explain in space provided (add details).

	Yes	No	Explanation
Normal Energy Level:	☐	☐	_____
Sleep Disturbances:	☐	☐	_____
Appetite Changes:	☐	☐	_____
Exercise:	☐	☐	_____
Anger/Hostility:	☐	☐	_____
Poor Concentration:	☐	☐	_____
Irritability/Agitation:	☐	☐	_____
Mood Swings:	☐	☐	_____
Obsessive Thoughts:	☐	☐	_____
Compulsions:	☐	☐	_____
Anxiety/Tension:	☐	☐	_____
Memory Problems:	☐	☐	_____
Fearfulness:	☐	☐	_____
Hallucinations:	☐	☐	_____
Paranoid Thoughts:	☐	☐	_____
Delusions:	☐	☐	_____
Depressed Mood:	☐	☐	_____
Hopelessness:	☐	☐	_____
Suicidal Thinking:	☐	☐	_____
Homicidal Thinking:	☐	☐	_____
Family/Peer Support:	☐	☐	_____
Social Isolation:	☐	☐	_____
Caffeine Use:	☐	☐	_____
Cigarette Smoker:	☐	☐	_____
Alcohol:	☐	☐	Frequency: _____ Amount: _____ Last Used: _____
Drug Use:	☐	☐	Type(s): _____ Amount: _____ Last Used: _____

Current Medications

Name	Dosage	Date Began	Prescribed by
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Client's Name: _____

	Yes	No	Explanation
Violent Behavior:	☐	☐	_____
Law/Arrest Issues:	☐	☐	_____
Legal Issues:	☐	☐	_____
Prior Therapy:	☐	☐	With Whom: _____
			Dates: _____
Prior Psychiatric Treatment:	☐	☐	Where: _____
			Dates: _____
			Diagnosis: _____
Psychiatric Hospitalization:	☐	☐	Where: _____
			When: _____

All General Medical Conditions

Hepatitis:	☐	☐	_____
Thyroid Disease:	☐	☐	_____
AIDS:	☐	☐	_____
Diabetes:	☐	☐	_____
Heart Disease:	☐	☐	_____
Gastrointestinal:	☐	☐	_____
Epilepsy (Seizures):	☐	☐	_____
Migraine Headaches:	☐	☐	_____
Cancer:	☐	☐	_____
Drug Allergies:	☐	☐	List: _____
Other:	☐	☐	_____
Hospitalizations:	☐	☐	Where: _____
			When: _____

Family Information

Have members of your family ever had any of the following problems? (parents, grandparents, uncles, aunts, brothers, sisters, and/or children)

Depression:	☐	☐	_____
Anxiety:	☐	☐	_____
Manic Depression/Bipolar:	☐	☐	_____
Suicidal Attempt:	☐	☐	_____
Completed Suicide:	☐	☐	_____
Mental Retardation:	☐	☐	_____
Learning Disability:	☐	☐	_____
Schizophrenia:	☐	☐	_____
Alcohol Abuse:	☐	☐	_____
Drug Abuse:	☐	☐	_____

Highest Education Attained: _____

Religious/Faith Orientation: _____

Disability (are you presently on disability or have you been in the past?) Explain:

_____

_____