TIFTAREA
PSYCHIATRIC AND COUNSELING SERVICES, LLC
223 East Second Street, Suite B – Post Office Box 1613 – Tifton, Georgia 31793
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Name: _____ Date: _____

Reason for entering into services? _____
_____

Please check any symptoms that describe how you feel, think, or behave currently or within the last 3 months:

	Abdominal pain		Aggressive/abusive towards other
	Agitation		Attempts to harm self
	Avoidance of public places		Back pain
	Change in ability to walk		Chest pain
	Chest tightness		Chronic sadness
	Confused/worried about sexual behavior		Constipation
	Crying episodes		Diarrhea
	Difficulty at work/school		Difficulty completing tasks
	Difficulty concentrating		Difficulty focusing
	Difficulty functioning socially		Difficulty making decisions
	Difficulty waiting your turn		Dizziness
	Easily startled		Excessive gambling
	Excessive spending		Excessive worry
	Fainting		Fear of dying
	Fear of leaving home		Fear of loss of control
	Fearfulness		Frequent forgetfulness
	Frustration		Hard to stay with job very long
	Hopelessness		Intrusive thoughts of bad memories
	Irritability		Legal problems
	Change in eating habits: stress eating/loss of appetite		Low energy/fatigue
	Marital conflict		Memory problems
	Multiple sexual partners		Muscle stiffness
	Muscle weakness		Nausea/Vomiting
	Neck Pain		Nightmares
	Not well organized		Overeating
	Panic attacks		Physical abuse
	Pounding heart/palpitations		Problems with co-workers

Continued

	Racing thoughts		Reduced interest in activities
	Re-living bad experiences		Restlessness
	School problems		Seeing/hearing things others don't
	Seizures		Sexual abuse/rape (recent or past)
	Shortness of breath		Sleep problems
	Snoring		Staying up for days without sleep
	Taking on too many tasks		Tendency to act impulsively
	Thoughts of physically hurting others		Thoughts of suicide/homicide
	Trembling/shaking		Vision changes
	Withdraw from others		Self-Injury without suicide attempt (i.e. cutting, hair pulling, and banging of head etc.)

Please describe why you are seeking help at this time_____
_____

Has any member of your family been hospitalized for mental health concerns?
_____
If yes, please list who, when and for what reason_____
_____
_____

Do/did you have any family members who have/had problems with drinking alcohol or using drugs? _____
If yes, please list who, when and if it is still a problem: _____
_____

Has any member of your family attempted/committed suicide?
_____
If yes, Please list who, when, and what happened: _____
_____

What is your **best** memory about your family when growing up?
_____
_____
_____

If you could change anything about your family situation right now, what would it be?
_____
_____

Have you ever seen a counselor, psychologist, psychiatrist, or other mental health professional for any mental health or drug/alcohol concerns?

_____

If yes, please list who, when and why: _____

_____

Have you ever been hospitalized for mental health or drug/alcohol concerns?

_____

If yes, please list when and for what reason: _____

_____

Do you have thoughts of harming yourself? _____ if so, how often does this happen?

_____

Have you ever tried to harm yourself? _____ If so, when did this happen?

_____

Did you receive medical help at the time? _____

Current Medications

(Please include prescription, over the counter, herbs, vitamins, and other remedies)

Medication	Dosage/when taken	Reason taking	Prescribing Doctor

Allergies to medications: _____

_____

Please list any current medical problems or concerns: _____

_____

Please list any past serious illnesses, surgeries or health concerns:

_____

_____

Exercise and Physical Recreational Activity

Type of activity How often

_____
_____
_____

Would you describe yourself as physically active? _____

Do you currently have a primary care physician? If so, please list his/her name:
_____
Are you currently under the care of any other physicians? If so, please list names:
_____
_____
_____

Use of substances (on average)
If none, please leave blank.

	Current Amount	**Most used in Past**
Alcohol	_____ number per day _____ number per week _____ number per episode Type of alcohol_____ _____ (beer, whiskies, wine etc.) Size of drinks_____ _____ (can, "tallboy", shots, etc.)	_____ number per day _____ number per week _____number per episode Type of alcohol_____ _____ (beer, whiskies, wine etc.) Size of drinks_____ _____ (can, "tallboy", shots, etc.)
Tobacco	__ cigarettes _____ per day __ cigars _____ per day __ smokeless_____ cans per day	__cigarettes _____ per day __cigars _____per day __smokeless _____ cans per day
Caffeine(tea, coffee, soda)	_____ servings per day	_____ servings per day
Marijuana	_____ per day _____ per week	_____ per day _____ per week
Cocaine	_____ times per day _____ times per week	_____ times per day _____ times per week

Pills	_____ pills/doses per day _____ pills/doses per week Type of pills_____ _____ (pain pill, Xanax etc.)	_____ pills/doses per day _____ pills/doses per week
Cocaine	How often used_____ _____ (daily, weekly, occasional) Amount used_____	How often used_____ _____ (daily, weekly, occasional) Amount used_____
Methamphetamines	How often used_____ _____ (daily, weekly, occasional) Amount used_____	How often used_____ _____ (daily, weekly, occasional) Amount used_____
Heroin	How often used_____ _____ (daily, weekly, occasional) Amount used_____	How often used_____ _____ (daily, weekly, occasional) Amount used_____
Molly	How often used_____ _____ (daily, weekly, occasional) Amount used_____	How often used_____ _____ (daily, weekly, occasional) Amount used_____
Hallucinogens - Mushrooms/Mushroom tea, LSD, etc.	How often used_____ _____ (daily, weekly, occasional) Amount used_____	How often used_____ _____ (daily, weekly, occasional) Amount used_____
Ecstasy	How often used_____ _____ (daily, weekly, occasional) Amount used_____	How often used_____ _____ (daily, weekly, occasional) Amount used_____
Synthetic drugs i.e. bath salts, spice etc.	How often used_____ _____ (daily, weekly, occasional) Amount used_____	How often used_____ _____ (daily, weekly, occasional) Amount used_____
Other_____ _____	How often used_____ _____ (daily, weekly, occasional) Amount used_____	How often used_____ _____ (daily, weekly, occasional) Amount used_____

Marital status: _____
Have you ever been married/partnered? _____
How many times? _____ Longest relationship? _____
Reason for ending marriages/partnerships? _____
_____
_____

Number of Children: _____
Do you have custody? _____ If no, who has custody_____

Education: _____ Difficulties with education_____

Living arrangements: _____

Employment: _____

Military service: _____ Branch _____
Active duty/Discharged/Retired (please circle correct option)
If discharged type of discharge_____ MOS _____ (job)
Combat experience yes/no (circle) Military sexual trauma yes/no (circle)
Are you currently eligible for or receiving VA Benefits/Treatment? _____

***If you need records sent to the VA please provide a release of information and specify which VA facility/department records need to be sent to**