TRI-COUNTY MENTAL HEALTH SERVICES, INC.

CLIENT NAME: ______________________________ DATE OF BIRTH: _______________
Name of person completing form: ______________________ and Relationship: ________________

<u>Please answer the following as completely as you can for the individual who will receive services. This will assist us in providing the most appropriate care.</u>

Briefly describe why you are seeking services at Tri-County Mental Health Services?

____
____
____

CURRENT SYMPTOMS

☐ Loss of interest in things I used to enjoy
☐ Decreased Appetite
☐ Decreased Motivation
☐ Sleeping too much
☐ Difficulty falling/staying asleep
☐ Irritability
☐ Low Self-Esteem
☐ Poor Concentration
☐ Sadness
☐ Tiredness
☐ Crying spells
☐ Withdrawal from others

☐ Hopelessness
☐ Thoughts of Harming Self
☐ Thoughts of Harming Others
☐ Self Harm behaviors
☐ Aggression towards others

☐ Fire Setting
☐ Gambling problems
☐ Inattention
☐ Impulsivity
☐ Substance Use
☐ Stealing
☐ Family Conflict
☐ Sexual Problems
☐ Anger

☐ Anxiety
☐ Flashbacks
☐ Nightmares
☐ Fear or anxiety around others

☐ Hearing sounds or voices others don't hear
☐ Recurring unwanted thoughts
☐ Paranoia
☐ Seeing things that others don't see

☐ Defiance
☐ Toileting problems
☐ Hyperactivity
☐ School Problems
☐ Separation Anxiety
☐ Temper Tantrums
☐ Aggression towards others
☐ Difficulty focusing on school work

☐ Chronic Pain
☐ Headaches
☐ Nausea
☐ Rapid Heart Beat
☐ Shortness of Breath
☐ Slow Heart Beat
☐ Stomach Aches
☐ Sweating

☐ Weight Gain
☐ Weight Loss
☐ Concerns about my weight
☐ Concerns about my appearance
☐ Frequent dieting

Any other symptoms not already mentioned: ____
____

Do you ever drink alcohol? ☐ **Current use** ☐ **Past use** ☐ **Never**
Have you ever used marijuana or other illegal drugs? ☐ **Current use** ☐ **Past use** ☐ **Never**
Do you use tobacco? ☐ **Current use** ☐ **Past use** ☐ **Never**
Have you ever taken more medication than was prescribed or taken prescription medication not prescribed to you? ☐ **Yes** ☐ **No**

PERSONAL INFORMATION

Relationship History:
☐ Single ☐ Married ☐ Significant Relationship ☐ Separated ☐ Divorced ☐ Widowed

Sexual Orientation:
☐ Straight/Heterosexual ☐ Lesbian/Gay/Homosexual ☐ Bisexual ☐ Don't know
☐ Something else (please specify): __________________ ☐ Prefer not to answer

What is your current gender identity?
☐ Male ☐ Female ☐ Female-to-Male (FTM)/Transgender Male
☐ Male-to-Female (MTF)/Transgender Female ☐ Genderqueer, neither exclusively male nor female
☐ Prefer not to answer ☐ Other (please specify):______________________

HEALTH INFORMATION:

Are you currently taking any medications? ☐ Yes ☐ No
If yes, please list all:
____
____
____

Who prescribed these medications? ____

Are you taking any Over-the-Counter Supplements? ☐ Yes ☐ No
Describe: ____

Allergies/Adverse Reactions? ☐ Yes ☐ No
Describe: ____

Are you pregnant or attempting pregnancy? ☐ Yes ☐ No ☐ N/A
If yes, have you been receiving prenatal care? ☐ Yes ☐ No ☐ N/A

What are your goals for treatment at Tri-County Mental Health Services, Inc.?
____
____

____ **Date:** _____________________
Signature of Person Completing this form

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