A Place to Talk, LLC
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Presenting issue and treatment History

Date:

Name: _____

Age: _____ Date of birth: _____

- Reason (s) seeking treatment:

- Check current symptoms:

Mental Health		**Medical**
Anger	Shortness of breath	Headaches
Irritability	(identity) Confusion	Pain
Anxiety	Trouble thinking	Nausea/vomiting
Depression	Self critical	Seizures
Lack of energy	isolation	Memory loss
Loss of interest	Sleep difficulties	Other:
Hopelessness	Helplessness	
Changes in appetite	Disorientation	
Mood swings	Impulsivity	
Repetitive thoughts	Suspiciousness	
Suicidal ideation	Homicidal ideation	
Obsessive preoccupations	Hearing or seeing things	
Substance use	Substance abuse	
Drug of choice:		

- History of **mental health treatment**: Please include name of facility, length of service, and type of service (inpatient, IOP, outpatient, individual counseling, therapeutic or support groups.

- History of **medical treatment**: Please include name of facility, length of service, and type of service: Inpatient and/or outpatient services.

- Last physical was completed on _____ .

  - Current providers:

    - PCP - Name & phone number:

- Current Medications (medical, psychotropic, and supplements/homeopathic):

Name	Dosage	Taken for	Prescriber

- Adverse reactions to ANY medications/drugs?

- To the best of your knowledge, have you ever been treated for or had an indication of:

Visual disturbances, dizziness, severe headaches, weakness or paralysis or arms and legs, fainting, strokes?	Y / N
Persistent cough, coughing blood, shortness of breath, asthma, allergies, hay fever, bronchitis, pneumonia, emphysema, tuberculosis?	Y / N
Disorders of the eyes, ears, or throat?	Y / N
Chest pains, rheumatic fever, heart murmur, palpitations, high blood pressure?	Y / N
Frequent or persistent nausea or vomiting, vomiting blood or passing blood in stool, abdominal pain, frequent diarrhea or constipation, history of ulcers, hepatitis, jaundice, intestinal bleeding, colitis , irritable bowel syndrome, appendicitis, hemorrhoids, recent weight loss?	Y / N
Increased urinary frequency, pain or burning urination, passing blood in urine, history of kidney stones or urinary tract infection, diabetes?	Y / N
Rashes, chronic skin disorders, arthritis, or gout?	Y / N
Any known thyroid condition?	Y / N
Blackouts (not connected to substance use), convulsions, seizures, epilepsy?	Y / N
Syphilis, gonorrhea, herpes, HIV/AIDS, or other sexually transmitted disease?	Y / N

For women only:

- Do you experience physical and/or emotional difficulties prior to or during your period? If yes, please explain: Yes No

- How many times have you been pregnant?
  - Number of pregnancies carried to full term?
  - Infertility issues? Yes No
  - Miscarriage (s)? Yes No ---- Abortion (s)? Yes No
  - Any complications (including emotional) or current concerns?

- Have you experienced menopause? Yes No

- Have you begun having symptoms of menopause (hot flashes, irregular/missed periods, sleep disturbance, unusual mood changes)? Yes No

- If yes, please describe:

- Indicate Employment history:

Currently employed at/since:

Prior employment:

- Highest level of education attained:

- Indicate any history of involvement with the law.

- Military Services:

- Trauma history (check which applies)

Childhood Adult (Domestic Violence, elder abuse, etc) Past/current

Physical abuse Sexual abuse Emotional abuse Severe childhood neglect

- Specify abuse history

- Family Dynamics

- Spiritual and/or cultural preferences?

Please note any additional information you believe to be pertinent to A Place to Talk services.

Thank you for providing this information.

Print & Sign	Date

Luisa V Nagore, LPC	Date

Complete by:

For official use only:

Clinical summary & diagnostic impression

Completed by Luisa Nagore, LPC. Date