Allied
Mental Health Specialist Group

Client Data

Name: DOB: Who referred you for today's visit?

Please check: ☐ Single ☐ Married ☐ Remarried ☐ Divorced ☐ Cohabiting ☐ Widowed

Brief description of your reason for your visit:

What do you hope to gain from today's visit and /or therapy:

Presenting Symptoms:

☐ Lack appetite/overeating	☐ Fatigue/Lack of energy	☐ Irritability/impatience	☐ Obsessive
☐ Restricted/ binge eating	☐ Poor concentration	☐ Hyperactive/restless	☐ Flashbacks
☐ Weight loss/gain	☐ Day dreaming	☐ Sexual Concerns	☐ Nightmares
☐ Stomach aches	☐ Trouble with sleep	☐ Compulsions/impulsive	☐ Hypomanic/manic
☐ Headaches	☐ Inability to cry	☐ Chemical abuse	☐ Mood swings
☐ Body aches	☐ Crying spells	☐ Impaired thoughts	☐ Suicidal thoughts
☐ Depressed/sad	☐ Anxiety/Panic	☐ Impaired judgements	☐ Suicidal plans
☐ Lack of motivation	☐ Distrust of others	☐ Helpless/Hopeless	☐ Attempted suicide
☐ Fears/Worries	☐ Angry/resentful	☐ Relational problems	☐ Irresponsible
☐ Withdrawn/isolated	☐ Anger verbal/physically		
☐ Worthlessness/guilt			

How long have these symptoms been present?

Have you attended therapy in the past: ☐ Yes ☐ No

Medical Provider: Clinic Name and town:

Current Medications and dosages:

Name	Dosage

Current Medical Conditions:

Any infectious diseases within past year: ☐ Yes ☐ No

Allergies to Medications:

Other known allergies:

Currently living (town): Place of birth:

Employed: ☐ Yes ☐ No

Hobbies/Activities/Interests:

Religious/Spiritual Beliefs:

Financial problems? ☐ Yes ☐ No

Current Legal Involvement? ☐ Yes ☐ No

Education:

Degree: School attended: Graduation date (year):

Spouse/Partner: Years together: Years married: Divorced (year):

Separated (duration):

Child Name	Age

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Father's Age: ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Remarried ☐ Co-habitating ☐ Deceased

Mother's Age: ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Remarried ☐ Co-habitating ☐ Deceased

Sibling Name	Gender	Age

Do any Family members have or ever been treated for a mental health related problem? ☐ Yes ☐ No
If yes, please list family member(s) and a brief explanation:

Has any family member has a history of substance abuse or substance abuse treatment? ☐ Yes ☐ No
If yes, please list family member and brief explanation.

Risk Assessment	**Current**	**History**	**Comments:**
Fleeting thoughts of suicide	☐ Yes ☐ No	☐ Yes ☐ No	
Suicidal Plans	☐ Yes ☐ No	☐ Yes ☐ No	
Homicidal thoughts	☐ Yes ☐ No	☐ Yes ☐ No	
Homicidal Plans	☐ Yes ☐ No	☐ Yes ☐ No	
Self-Injurious Behaviors	☐ Yes ☐ No	☐ Yes ☐ No	