Office of: Sarah Horvath, LCSW
Self-Report Form Page 1

Client's Name: _____

Person completing report: _____Relation to Client: _____

_____
Street City State Zip

_____
Home Phone Work Phone Cell Phone

Email: _____

Date of Birth: _____ Age: ___ Gender: M F

Marital Status: Single Married Widowed Divorced Separated Partnered

Circle if applicable- Employment Status: FT or PT Retired Non-employed Other_____

Student: Full-time Part-time Grade _____ School _____

Occupation: _____Employer: _____

Current or past Education: _____

Whom may we thank for referring you? _____

Please list immediate and/or significant family/partners/friends:

Name Age Relation Where do they live? Married? /Have children? Other info

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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Self-report page 2
Client's Name_____

The following questions will help in providing you the best treatment possible. It is helpful but not mandatory to answer these questions. If there is a question you are unsure of, have questions about or are uncomfortable answering, just leave it blank. If a question does not pertain to you or the client, just leave it blank. Please read and answer each question carefully.

What is the reason you are seeking treatment?

_____
_____
_____

Have you ever been treated for psychiatric issues or chemical dependence? Yes No
If yes, please list below the diagnosis, when, where, and by whom if you know.

_____
_____

Please list any traumatic or extremely upsetting events that have happened to you and the general dates of occurrence.

._____
_____

<u>Are you experiencing any of the following?</u>

Depression: Yes No
Loss of interest in activities: Yes No
Loss or increase in appetite: Yes No
Significant weight loss or gain: Yes No
Increase or decrease in sleep: Yes No
Increase or decrease in energy level: Yes No
Feelings of worthlessness or guilt: Yes No
Problems in concentration or decision making: Yes No
Thoughts about death, suicide, or self-harm: Yes No
Anxiety: Yes No
Panic or anxiety attacks: Yes No
Fears: Yes No
Nightmares: Yes No
Increased or decreased appetite: Yes No
Concerns about body image: Yes No
Persistent unpleasant thoughts: Yes No
Times when you engage in repetitive behaviors: Yes No
Worries about physical health, finances, other: Yes No
Other: _____
Other: _____

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Self-Report page 3

Client's name_____

Have you had any of the following:

Periods of at least 4 days when you were so happy or excited you got into trouble or others became worried about yourself? Yes No

Periods of at least 4 days of irritability or temper problems? Yes No

Racing thoughts or an inability to keep up with your thoughts? Yes No

Thoughts that others are "out to get you?" Yes No

Hallucinations (i.e. seeing, hearing, or feeling, something others cannot? Yes No

Memory problems? Yes No

Substance Use/Abuse History

How many times during the month do you consume alcohol?

How much do you drink each time?

Do you use any illegal drugs (Marijuana, Cocaine, Amphetamines, Heroin, other)? Yes No If yes, please list below.

Have you used any illegal drugs in the past? Yes No

If yes, please list below, and time of last use.

Have you ever abused prescription medications or over-the-counter medications such as pain medications, narcotics, anxiety medications, tranquilizers, or sleeping medications? Yes No If yes, please describe below:

Have you ever participated in NA/AA or other self-help programs? Yes No

How many caffeine products (soda, coffee, energy drinks) do you consume each day?

Do you use tobacco products? Yes No
If yes, please describe below what you use and how much.

Office of Sarah Horvath, LCSW

Self-Report page 4

Client's name_____

Your Family History This is about you AND your relatives

(Medical - Please indicate who and relation)

High blood pressure : Yes, Who? _____ or No

Heart disease: Yes, who? _____ or No

Diabetes: Yes , who? _____ or No

Seizures: Yes, who? _____ or No

Cancer: (what kind) Yes, who? _____ or No

Thyroid problems: Yes, who? _____or No

(Mental Health - Please indicate who and relation)

Depression: Yes, who?_____or No

Bipolar disorder: Yes, who? _____or No

Anxiety disorders : Yes, who? _____or No

Schizophrenia: Yes, who? _____or No

Alcoholism: Yes, who? _____ or No

Cognitive impairments or learning disabilities: Yes, who? _____or No

Drug addiction: Yes, Who? _____or No

Suicides/attempts: Yes, who? _____or No

Other: (please describe) _____

Other: (please describe)_____

Client's name_____

Medical history

Please list any *current* medical problems and the name of your treating physician:

_____
_____
_____

Please list all current medication: Please include over the counter and prescription medication

Name	Dose	Frequency/time	Reason	starting date	Prescribing Doctor

Please list all *past* psychiatric medications and effects (helpful or not, side effects etc.):

_____

_____

_____

_____

_____

_____

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Self-Report page 6

Client's name_____

Are you allergic to any medications? Yes No
If yes, please list below:

Have you ever experienced head trauma with loss of consciousness? Yes No
If yes, please list with date and description:

Have you ever experienced seizures? Yes No
If yes, please list with date and description:

If you are a woman, are you pregnant or plan to be? Yes No Unsure

Have you ever been hospitalized for major surgeries or illness? Yes No
If yes, please list diagnosis, and when.

Do you plan to join the military or are you currently enlisted? Yes No

Are you adopted? If so at what age? _____

When you were born:
Any complications? _____
Birth weight? _____ Developmental milestones reached as expected? _____

Notes:_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you!