Office of: Sarah Horvath, LCSW

Self-Report Form

Client Information

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

Employment Status: Full-time Part-time Retired Non-employed If Student: Full-time Part-time

Occupation:_____Employer:_____Position_____

School/Grade (if student):_____

Emergency Contact – Name/ Phone/ Relation to Client:_____

Whom may we thank for referring you?_____

Why are you seeking treatment?_____

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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Office of Sarah Horvath, LCSW
Self-report page 2
Client's Name_____
Person/relation to client completing form_____

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.

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.
_____
_____

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

Are you experiencing any of the following?

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

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Client's name_____

Periods of at least 4 days when you were so happy or excited you got into trouble or others became worried about you? 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.

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Self-Report page 4

Client's name_____

Family History

(Medical - Please indicate who and relation)

High blood pressure Yes No

Heart disease Yes No

Diabetes Yes No

Seizures Yes No

Cancer (what kind) Yes No

(Mental Health - Please indicate who and relation)

Depression Yes No

Attention deficit Yes No

Bipolar disorder Yes No

Anxiety disorders Yes No

Schizophrenia Yes No

Alcoholism Yes No

Cognitive impairments or learning disabilities Yes No

Drug addiction Yes No

Suicides/attempts Yes No

Other (please describe) Yes No

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Self-Report page 5

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

_____

_____

_____

_____

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

_____

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_____

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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

NOTES:_____

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