Exeter Counseling Center, PLLC
SYMPTOM AND HISTORY FORM

Name: _____ DOB: _____ Age: _____

Please describe the problem/issues that led you to schedule this appointment:

_____

_____

_____

_____

Please check all symptoms and behaviors that you consider problematic:

☐ Depressed Mood	☐ Trouble sleeping	☐ Trouble concentrating
☐ Anxiety	☐ Nightmares	☐ Distractibility
☐ Panic Attacks	☐ Low energy/fatigue	☐ Racing thoughts
☐ Irritability/Anger	☐ Change in appetite	☐ Memory problems
☐ Phobia/specific fears	☐ Loss of pleasure/interest	☐ Recurring upsetting memories
☐ Loneliness	☐ Lack of motivation	☐ Obsessive thoughts
☐ Hopelessness	☐ Social discomfort	☐ Compulsive behaviors
☐ Low self worth	☐ Social withdrawal	☐ Hyperactivity
☐ Guilt/shame	☐ Avoidance	☐ Impulsivity
☐ Suicidal thoughts	☐ Alcohol/drug abuse	☐ Confusion/disorganization
☐ Homicidal thoughts	☐ Gambling problems	☐ Flashbacks
☐ Elevated Mood	☐ Computer addiction	☐ Suspicion/paranoia
☐ Mood swings	☐ Aggressive behavior	☐ Hallucinations

Are your problems affecting any of the following?

☐ Work/School	☐ Health	☐ Self-esteem	☐ Leisure activities
☐ Family Relationships	☐ Finances	☐ Self-care	☐ Housing
☐ Social Relationships	☐ Legal Issues	☐ Sexual functioning	☐ Decision-making

Have you ever had suicidal thoughts, made suicidal statements, or attempted to hurt yourself? ☐ Yes ☐ No
If yes, please describe:

_____

_____

_____

Previous Mental Health Treatment

Treatment	When	Provider/Program	Reason for Treatment
Outpatient Counseling			
Psychiatric Hospitalization			
Drug/Alcohol Treatment			
Support Groups			

Family History

Relationship	Name	Age	Length / Quality of Relationship	Mental Health or Substance Abuse Dx?
Spouse/partner				
Children				
Mother				
Father				
Siblings				

Please indicate any other significant family history of psychiatric or substance abuse disorders:

_____

_____

Please check if you have experienced any of the following:

☐ Parental divorce	☐ Emotional abuse	☐ Separation from family
☐ Significant family illness	☐ Physical abuse	☐ Adoption
☐ Loss of loved one	☐ Sexual abuse	☐ Blended family
☐ Parental substance abuse	☐ Violence in the home	☐ Divorce (self)
☐ Neglect	☐ Poverty	☐ Custody/Co-Parenting Conflicts

Medical Information

Current medical concerns: _____

_____

_____

Have you experienced any of the following medical conditions?

☐ Alleriges	☐ Chronic Pain	☐ Hearing Problems	☐ Sleep Disorder
☐ Anemia	☐ Diabetes	☐ Heart Disease	☐ Stroke
☐ Arthritis	☐ Dizziness/Fainting	☐ High Blood Pressure	☐ Thyroid Problem
☐ Asthma	☐ Headaches	☐ Seizures	
☐ Cancer	☐ Head Injury	☐ Sexual Dysfunction	

Current prescription medications:

Medication	Dosage	How long?	Prescribed by

Current over-the-counter medications or supplements: _____

_____

_____

Medication/Food Allergies: _____

Substance Use History

Substance	Amount	Frequency	Date of last use	Years of use
Alcohol				
Marijuana				
Cocaine/Crack				
Hallucinogens				
Stimulants				
Opioids				
Heroin				

Have you ever experienced withdrawal symptoms when trying to stop using substances? If yes, please describe:

_____

Have you every had problems with work, relationships, health, the legal system, etc due to your substance use? If yes, please describe: _____

_____

Social History

Employment

Employer: _____ Postion: _____

Length of time in this position: _____ Job Duties: _____

Stress level of this job: ☐ Low ☐ Medium ☐ High

Additional Job History: _____

Education

Are you currently attending school? ☐ Yes ☐ No

☐ High School Graduate? or ☐ GED Year _____

☐ Associates Degree Year _____ Major area of study _____

☐ Bachelor's Degree Year _____ Major area of study _____

☐ Graduate Degree Year _____ Major area of study _____

Military Service

☐ Yes ☐ No Have you been/are you currently serving in the military?

Branch _____ Rank _____ Date of Discharge _____ Type of Discharge _____

Did you serve in combat? ☐ Yes ☐ No

Legal

☐ Yes ☐ No Have you been convicted of a misdemeanor or felony?

☐ Yes ☐ No Are you currently involved in any divorce or child custody proceedings?

☐ Yes ☐ No Are you currently involved in any proceedings involving legal litigation or disability determination?

If yes to any of the above, please describe:

_____

_____

Social/Interpersonal

Please describe your social support network (check all that apply):

☐ Family	☐ Neighbors	☐ Friends	☐ Co-workers
☐ Religious Organization	☐ Self-Help Group		

Ethnicity? _____ Sexual Orientation? _____

Please describe any areas of special interest or hobbies: _____

Exercise, including frequency? _____

Please describe your strengths, coping skills, and most important social supports: _____

_____

_____