Name_____ Date_____

# ADMISSION CHECKLIST

*Please check any of the following that are of concern to you:*

__1. Depressed mood
__2. Crying spells
__3. Sleep difficulties
__4. Difficulty with motivation
__5. Irritability
__6. Mood swings
__7. Weight loss or gain
__8. Anxiety or panic attacks
__9. Perfectionistic thinking
__10. Problems with eating
__11. Unwanted behavior: habits or compulsions
__12. Problems with anger
__13. Aggressive or violent behavior
__14. Suicidal thoughts
__15. Self-injurious behavior
__16. Past experience of physical or sexual abuse
__17. Chemical use
__18. Trouble with memory or concentration
__19. Confusion
__20. Unusual thoughts
__21. Easily distracted
__22. Difficulty completing tasks
__23. Hearing voices or seeing things that others don't see or hear
__24. Relationship problems
__25. Sexual concerns
__26. Grief/ loss
__27. Concerns with parenting
__28. Work-related concerns
__29. Problems with school
__30. Legal problems
__31. Money management
__32. Physical problems
__33. Recent changes in physical health
__34. Muscular tension
__35. Frequent headaches
__36. Menstrual difficulties
__37. Infertility
__38. Other (specify):_____
_____

*How do these concerns affect your ability to function at work, school, and/or home? Please describe.*

*Previous or current therapy. Please list any treatment you have received.*

| Therapist/Provider | Dates | Purpose | Satisfied with outcome? |
|---|---|---|---|
| | | | |

*Please indicate the frequency with which you use:*

| | more than once/day | daily | weekly | monthly | less than monthly | used to | never |
|---|---|---|---|---|---|---|---|
| cigarettes | ____ | ____ | ____ | ____ | ____ | ____ | ____ |
| coffee | ____ | ____ | ____ | ____ | ____ | ____ | ____ |
| alcohol | ____ | ____ | ____ | ____ | ____ | ____ | ____ |
| marijuana | ____ | ____ | ____ | ____ | ____ | ____ | ____ |
| tranquilizers | ____ | ____ | ____ | ____ | ____ | ____ | ____ |
| barbiturates | ____ | ____ | ____ | ____ | ____ | ____ | ____ |
| cocaine | ____ | ____ | ____ | ____ | ____ | ____ | ____ |
| amphetamines | ____ | ____ | ____ | ____ | ____ | ____ | ____ |
| hallucinogens | ____ | ____ | ____ | ____ | ____ | ____ | ____ |
| heroin | ____ | ____ | ____ | ____ | ____ | ____ | ____ |
| other | ____ | ____ | ____ | ____ | ____ | ____ | ____ |

(OVER)

*Have you been concerned about your drinking/ drug use habits?* Yes____ No____ *Please describe.*

*Has anyone ever voiced concern regarding your alcohol or drug use?* Yes____ No____ *Please describe.*

*Have there ever been concerns about the alcohol or drug use of a significant person in your life?*
Yes____ No____ *Please describe.*

*Have you been in treatment for alcohol or drug use?* Yes____ No____ *Please describe.*

*Briefly describe your living situation (people, pets, rent/roomer/own place)*

*Education/training:*

*Briefly describe what exercise you get each week and how often.*

*Date of last physical exam:*_____

*Name of physician:*_____
*address:*_____
_____*phone number:*_____

*Have there been any recent changes in your physical condition?* Yes____ No____ *Please describe.*

*List any medical problems or symptoms you are currently experiencing or for which you are receiving treatment:*

*List any medications (and dosages) you are presently taking:*

*What brings you to therapy at this time?*

*What resources or strengths have you used in dealing with the concerns you have identified?*

*Please list your goals for therapy:*

*Please indicate how long you expect therapy to last?*_____