Anat Fein, MA, LMFT

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Name _____ Age_____ Date of birth ____/____/____Who referred you?_____
Month Day Year

Address_____

Phone number(s)_____ , _____ (Okay to leave a message? ¨ Yes ¨ No)

Email address (optional) _____ Occupation_____

¬ Have you been in therapy before? ¨ Yes ¨ No ¬ Psychiatric hospitalization(s)? ¨ Yes ¨ No ¬ Head injuries? ¨ Yes ¨ No

¬ Are you currently taking any medications? ¨ Yes ¨ No **specify** _____

Reason for seeking therapy: _____

_____

¬ Please rate the severity of the following complaints according to the following scale:
0-No difficulty 1-Mild 2-Moderate 3-Severe N/A

_____ Appetite/weight change
_____ Guilt/shame
_____ Bingeing/purging/overeating
_____ Unusual sensations/perceptions
_____ Depressed mood
_____ Decreased energy/fatigue
_____ Sleep changes/problems
_____ Loneliness
_____ Loss/trauma
_____Trouble making decisions/doubts
_____ Low self esteem
_____ Difficulty with sexual functioning
_____ Loss of interest in activities
_____ Pulling out hair
_____ Feelings of hopelessness
_____ Feelings of helplessness
_____ Decreased attention span
_____ Inattentiveness/Distractibility
_____ Memory/concentration problems
_____ Problems with alcohol/substance
_____ Self-injurious behavior
_____ Mood swings
_____ Thoughts of suicide
_____ Thoughts of harming others/revenge
_____ Anxiety/worries
_____ Relationship/family problems
_____ Worries regarding health issues
_____ Frequent headaches (Respond to OTC medication? ¨ Yes ¨ No)

_____ Flashbacks
_____ Hyper vigilance
_____ Obsessive thoughts
_____ Compulsions
_____ Spending sprees
_____ Racing thoughts
_____ Rapid heartbeat
_____ Trouble breathing
_____ Sweating
_____ Phobia
_____ Frustration
_____ Nightmares
_____ Holding grudges
_____ Academic problems
_____ Occupational problems
_____ Trouble with the law/authority
_____ Worries regarding financial issues
_____ Impulsivity
_____ Hyperactivity
_____ Motor/vocal tics
_____ Anger/anger outbursts
_____ Crying spells
_____ Irritability/Agitation/Restlessness
_____Chronic pain/medical conditions
specify: _____
_____
_____

____other_____
____other_____
____other_____
____other_____

¬ Anything else I should know**?** _____

_____

Signature:_____ Relation to patient (if applicable**):** _____ **Date:**_____