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ADULT HISTORY

Name: _____ Date: _____

Address: _____

Phone #: _____ Work #: _____

DOB: _____ Age: _____ Occupation: _____

Referred by? _____

Reason for making appointment? _____

With whom are you now living? (list people):

Name	Age	Relationship	Occupation
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Medical History (include past and present conditions): _____

Medications: _____

Physician: _____

Previous Mental Health Treatment

When?	With Whom?	Outcome
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Family History of mental or emotional problems, including alcohol or substance abuse:

Educational History (Briefly describe school experiences, including highest grade level attained.)

Employment History

1. Present employment status and where: _____

2. Work related concerns? _____

Talents and skills: _____

Symptom Check List (**check all that apply to you**):

- | | | |
|--|--|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Feeling that you are not real | <input type="checkbox"/> Lose track of time |
| <input type="checkbox"/> Low energy | <input type="checkbox"/> Anger control problems | <input type="checkbox"/> Defies rules |
| <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Blames others | <input type="checkbox"/> Argues |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Alcohol/drugs | <input type="checkbox"/> Blackouts |
| <input type="checkbox"/> Worthlessness | <input type="checkbox"/> Appetite disturbance (more/less) | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Spousal abuse | <input type="checkbox"/> Sadness/loss |
| <input type="checkbox"/> Anxiety/panic | <input type="checkbox"/> Heart pounding/racing | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Trembling/shaking | <input type="checkbox"/> Chills/hot flashes | <input type="checkbox"/> Sweating |
| <input type="checkbox"/> Tingling/numbness | <input type="checkbox"/> Phobias | <input type="checkbox"/> Racing thoughts |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Delusions/hallucinations | <input type="checkbox"/> Relationship issues |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Sleep disturbance (more/less) | <input type="checkbox"/> Intrusive thoughts |
| <input type="checkbox"/> Self-injury | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Marital/family |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Impulse control problems | <input type="checkbox"/> Social withdrawal |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Thoughts of hurting yourself (past/present) | |
| <input type="checkbox"/> Physical abuse (past/present) | <input type="checkbox"/> Thoughts of hurting others (past/present) | |
| <input type="checkbox"/> Sexual abuse (past/present) | <input type="checkbox"/> Stomach/bowel problems | |
| <input type="checkbox"/> Excessive behaviors (spending/gambling/sex) | | |
| <input type="checkbox"/> Other (specify) _____ | | |

Signature _____ Date _____