

CURRENT SYMPTOM CHECKLIST

IDENTIFYING DATA

LASTNAME:

FIRSTNAME:

M.I.:

CLINICAL INFORMATION

PLEASE DESCRIBE YOUR SYMPTOMS:

PLEASE IDENTIFY ANY KNOWN CAUSES FOR YOUR SYMPTOMS:

PLEASE LIST YOUR CURRENT MEDICATIONS:

	MEDICATION	STRENGTH	HOW TAKEN	HOW LONG
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

PLEASE LIST PREVIOUS PSYCHIATRIC DIAGNOSES THAT HAVE BEEN MADE:

- 1.
- 2.

PSYCHHEALTH

COMPREHENSIVE MENTAL AND EMOTIONAL HEALTH CARE CLINICS OF ARIZONA
PSYCHIATRY, PSYCHOLOGY, COUNSELING & PSYCHOANALYSIS
<http://www.psychhealth.org>

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PLEASE LIST ANY CURRENT MEDICAL PROBLEMS THAT ARE BEING TREATED:

- 1.
- 2.
- 3.
- 4.

PLEASE DESCRIBE HOW YOU FEEL YOUR THERAPIST CAN BE OF MOST HELP TO YOU:

PLEASE CHECK ANY OF THE FOLLOWING SYMPTOMS THAT YOU ARE EXPERIENCING:

SUICIDAL THOUGHTS: [] **HOMOCIDAL THOUGHTS:** [] **HALLUCINATIONS:** []
MEMORY LOSS: [] **WEIGHT LOSS:** [] **INSOMNIA:** [] **CONFUSION:** []