

Tim F. Fitsimones, M.A., LMHC, CAP

P.O. Box 82
Winter Park, FL 32790

Professional Counseling Services
Licensed Mental Health Counselor
Certified Addictions Professional

Ph: 407-629-7114
Fax 407-629-7463

CLIENT NAME: _____ DATE: _____

Please indicate how you are affected by each item below by circling the appropriate number. Circle one number for each category.

Not a Problem - 1	A Slight Problem - 2	A Moderate Problem - 3	A Serious Problem - 4	A Severe Problem - 5
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YOUR PHYSICAL FUNCTIONS

- Sleep Pattern 1 2 3 4 5
- Eating Pattern 1 2 3 4 5
- Bladder Control 1 2 3 4 5
- Bowel Control 1 2 3 4 5
- Seizures or Convulsions 1 2 3 4 5
- Speech (stutter or stammer) 1 2 3 4 5
- Weight Problem 1 2 3 4 5
- Sexual Functioning 1 2 3 4 5
- Other _____

YOUR EXPERIENCE AT WORK

- General Performance 1 2 3 4 5
- Absenteeism 1 2 3 4 5
- Relating to Supervisors 1 2 3 4 5
- Relation to Co-Workers 1 2 3 4 5
- Other _____

YOUR BEHAVIOR

- Difficulty with Daily Routine 1 2 3 4 5
- Letting Other Take Advantage of you 1 2 3 4 5
- Hyperactivity (can't sit still) 1 2 3 4 5
- Repeating Certain Acts, again & again 1 2 3 4 5
- Physically Abusing Others 1 2 3 4 5
- Using Alcohol to Cope with Problems 1 2 3 4 5
- Using Drugs to Cope with Problems 1 2 3 4 5
- Lying 1 2 3 4 5
- Stealing 1 2 3 4 5
- Withdrawal from Others Socially 1 2 3 4 5
- Dependency (relying on others to make your decisions and take care of you) 1 2 3 4 5
- Suspiciousness (questioning others motives) 1 2 3 4 5
- Hostility (getting angry towards others) 1 2 3 4 5
- Other _____

YOUR FEELINGS & MOODS

- Depression (sadness) 1 2 3 4 5
- Euphoria (feeling "high") 1 2 3 4 5
- Sudden Changes in Mood for No Apparent Reason 1 2 3 4 5
- Anxiety (nervousness) 1 2 3 4 5
- Lack of Energy 1 2 3 4 5
- Feeling Angry 1 2 3 4 5
- Not Liking Self 1 2 3 4 5
- Not Liking Others 1 2 3 4 5
- Others _____

YOUR INNER THOUGHTS & IDEAS

- Thoughts about Hurting Yourself 1 2 3 4 5
- Having Unwanted Thoughts 1 2 3 4 5
- Worrying about Your Health 1 2 3 4 5
- Believing You are Inferior to others 1 2 3 4 5
- Believing You are Better than others 1 2 3 4 5
- Seeing things without apparent cause 1 2 3 4 5
- Hearing things without apparent cause 1 2 3 4 5
- Experiencing Confusion 1 2 3 4 5
- Memory 1 2 3 4 5
- Other _____

INDICATE IF YOU ARE CURRENTLY EXPERIENCING ANY OF THE FOLLOWING HEALTH PROBLEMS:

- | | | |
|--|---|---|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Colitis | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Backache | <input type="checkbox"/> Cough | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Change in Bowel Habits | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Change in Menstrual Pattern | <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Loss of Sexual Interest |
| <input type="checkbox"/> Change in Urinary Pattern | <input type="checkbox"/> Gastro-Intestinal Problems | <input type="checkbox"/> Loss or Increase in appetite |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Headache | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Problems with skin | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Problems with Muscles, Joints, Bones | OTHER: _____ |

Have you ever been confined to a psychiatric hospital? Yes No **If yes, list name of hospital and date(s)** _____
Have you ever tried to commit suicide? Yes No _____
Have you ever tried to harm someone else? Yes No _____

Please list medications and dosage you are now using even if occasionally, and for what purpose you take them:

Medications & Dosage _____

PERSONAL PHYSICIAN: _____ ADDRESS: _____

PHONE: _____ Date of Last Physical Exam: _____ I give consent for you to contact my doctor and obtain records yes no

HAVE ANY OF YOUR RELATIVES HAD:
 Alcoholism Drug Dependency
 Cardiac Problems Mental/Emotional Problems
 Diabetes High Blood Pressure
 Other _____

INDICATE THE AMOUNTS OF THE FOLLOWING SUBSTANCES YOU USE ON A DAILY BASIS:
 Alcohol _____ Tea _____ Coffee _____
 Tobacco _____ Drugs _____ Other _____

Signed

Date