

Ann J. Burke, MA, LMFT, License #40730
4030 Truxel Rd., Suite C-6
Sacramento, CA 95834

Biographical Information

Name: _____ Phone #: _____

Occupation: _____ How Long? _____

Physician: _____ Date of Last Visit: _____

Relevant medical conditions (History, current conditions, changes in condition):

Please list Medications & Prescribing Doctor:

Married Single Widowed Partner Name: _____ Relationship: _____

Children (Names & Ages): _____

History of Counseling, Psychiatric Hospitalizations, Alcohol and or Drug problems:

What brings you to counseling?

Why have you decided to come for counseling at this time? What has happened that makes you come now?

What would you like to change about yourself to make your situation better?

These symptoms may or may not be related to the problem which brings you to treatment. However, they help us plan your treatment.

- | | |
|---|---|
| <input type="checkbox"/> Trouble going to sleep | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Restless sleep | <input type="checkbox"/> hot or cold spells |
| <input type="checkbox"/> Waking up early & being unable to fall back to sleep | <input type="checkbox"/> Numbness or tingling in parts of your body |
| <input type="checkbox"/> Sleeping too much | <input type="checkbox"/> Allergy problems |
| <input type="checkbox"/> Feeling guilty | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Depressive feelings generally worse in morning | <input type="checkbox"/> Menstrual irregularity or distress |
| <input type="checkbox"/> Thoughts of suicide | <input type="checkbox"/> Asthma attacks |
| <input type="checkbox"/> Made suicide attempts | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Fatigue or loss of energy | <input type="checkbox"/> Irritable bowels, constipation |
| <input type="checkbox"/> Poor concentration & memory | <input type="checkbox"/> Tics |
| <input type="checkbox"/> Decreased sex drive | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Feelings of restlessness | <input type="checkbox"/> Overconsumption of sugar or sugar cravings |
| <input type="checkbox"/> Loss of pleasure in usual activities | <input type="checkbox"/> Eating disturbance |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Frequent colds or flu |
| <input type="checkbox"/> Feelings of worthlessness | <input type="checkbox"/> Minor accidents |
| <input type="checkbox"/> Weight loss/Gain | <input type="checkbox"/> Grinding teeth/jaw tension |
| <input type="checkbox"/> Feelings of sadness or depression | <input type="checkbox"/> Withdrawing from others |
| <input type="checkbox"/> Uncontrollable habits | <input type="checkbox"/> Feeling critical of others |
| <input type="checkbox"/> Arguing with others | <input type="checkbox"/> Feeling shy or uneasy |
| <input type="checkbox"/> Feeling people dislike you | <input type="checkbox"/> Difficulty communicating what you really feel or think |
| <input type="checkbox"/> Wanting to be left alone | <input type="checkbox"/> Feeling inadequate or less than others |
| <input type="checkbox"/> Feeling bored by others | <input type="checkbox"/> Other do not understand you |
| <input type="checkbox"/> Feeling alone even with others | <input type="checkbox"/> Others do not understand you |
| <input type="checkbox"/> Relationship problems | <input type="checkbox"/> Others not meeting your needs |
| <input type="checkbox"/> Afraid of losing control | <input type="checkbox"/> Avoid certain situations |
| <input type="checkbox"/> Light headedness, Shortness of breath, trembling | <input type="checkbox"/> Palpitations, sweating, chest pains, cold clammy hands |

Name (Print): _____

Signature: _____ Date: _____