PREMIER PSYCHOLOGICAL
COUNSELING & CONSULTING, PC
PREMIER TMS
o: 435.216.9290 | 435.865.9119 | f: 435.865.9115
1490 E Foremaster Dr., Suite 340 – St. George, Utah 84790
info@premierpcc.com

History and Presenting Problem

Client Name: _____ **Date**: _____

Reason for seeking services: _____
_____

Duration of symptoms: _____
_____

Has the client seen a counselor or psychologist before? ☐ Yes ☐ No
If yes, who, when, and for what reason(s)? _____
_____

Developmental and Education
History of birth or developmental problems: _____
_____

Check if there is a history of any of the following: ☐ head injury ☐ high fever
☐ chronic medical illness ☐ prenatal exposure to toxins such as drugs, alcohol
Please explain: _____
_____

Highest or current grade in school: _____
School Progress: _____
_____

Legal/ Behavior/ Conduct: _____
_____

Medical and Psychiatric
Name of Physician(s): _____
Current Health Conditions: _____
_____

Previous Medical and/ or Psychiatric Diagnoses: _____
_____
_____

List medications currently used: _____
_____

List medications previously used: _____

Check the word(s) that apply:

Handedness: ___ Right ___ Left

Thought processing: ___ racing ___ pressured ___ intrusive ___ obsessive
___ non-pressured

Predominant Mood: (Pick all that apply) ___ anxious ___ depressed ___ happy ___ sad
___ fearful ___ manic ___ just so-so ___ flat
___ other (please explain)_____

Appetite: ___ good ___ poor ___ fair ___ intense
Weight: ___ stable ___ loss ___ binging ___ binging/purging ___ gain

Experience of: ___ moderate exercise ___ pleasurable activities
___ pre-occupation with pleasurable activities ___ inability to have fun
___ stable enjoyable sex life ___ diminished interest in activities

Sleep: Number of hours/night: ___ ___ restful ___ unrestful
Waking up: ___ frequent ___ infrequent ___ very infrequent
___ mid-sleep disruption ___ insomnia ___ early waking

Experience of: ___ nightmares ___ night terrors ___ recurrent dreams

Current Symptoms

Rate the items with which you are currently having problems. Circle the number that best indicates the severity of the problem.

0=None 1=Minor 2=Moderate 3=Significant 4=Serious

Circle the word(s) in brackets that best define(s) each statement:

Thoughts of Self-Harm	0 1 2 3 4
Anxiety (Worry) (Fear) (Panic) (Phobia)	0 1 2 3 4
Feelings of (Depression) (Sadness)	0 1 2 3 4
Thoughts of (Death) (Suicide)	0 1 2 3 4
Sleep Disturbance	0 1 2 3 4
Mood Swings	0 1 2 3 4
Grief over (Death of Loved One) (Major Loss)	0 1 2 3 4
Abuse (Physical) (Domestic) (Emotional) (Ritual)	0 1 2 3 4
Sexual Abuse (Incest) (Rape)	0 1 2 3 4
Parent(s) had (Alcohol) (Drug) Problem(s)	0 1 2 3 4
Marriage Problems	0 1 2 3 4
Relationship Problems with Children	0 1 2 3 4
Problems with (Parents) (Family)	0 1 2 3 4
Problems (Work) (School) (Legal)	0 1 2 3 4
Sexual (Concerns) (Problems)	0 1 2 3 4
Problem (Alcohol) (Drugs) (Smoking) (Other)	0 1 2 3 4

Feelings of (Hopelessness) (Helplessness) (Despair) 0 1 2 3 4
Memory (Forgetfulness) (Changes) 0 1 2 3 4

History of self-harm: ☐ Yes ☐ No
If yes, please explain: _____

History of physical, sexual, or emotional abuse: ☐ Yes ☐ No
If yes, please explain: _____

Alcohol and drug use: ☐ Yes ☐ No
If yes, please explain: _____

History of hospitalization for psychiatric reasons? ☐ Yes ☐ No
If yes, please explain: _____

Personal Interests
List hobbies and leisure interests: _____

_____

Individual strengths/ positives: _____

_____

Personal support system: _____

Completed by: _____

Relationship to Client: _____