SENTARA
RMH Medical Center

Revised 06/14

**PRESENTING ISSUES**

**Full Name:** _____ **Age:** _____ **Marital Status:** ____ **Gender:** ____

What problems and/or life changes led you to seek counseling at this time?

_____

_____

When did these problems/struggles begin?

_____

_____

What changes do you hope counseling will help you achieve (your goals)?

_____

_____

How will you know when you've reached your goals?

_____

_____

Who is your family/primary care physician outside the hospital? _____

Physician Phone Number: _____

Would you like your therapist to communicate with your family physician listed above in order to coordinate your care? ☐ Yes ☐ No Please Initial: _____

Any significant medical problems/hospitalizations: _____

_____

_____

_____

Current Medications/Dosage For what conditions/diagnosis Prescribing Physician

_____

_____

_____

_____

_____

_____

_____

Please use the bottom of the second page if you need additional space.

**Please list any allergies**: _____

_____

Have you gained or lost weight in the past two (3) months? ☐ Yes ☐ No how much? _____

Comments: _____

Any concerns about your sleep? _____

_____

**On a scale of 1 – 10, how do you see you ability to function in your life right now? (circle)**

**Worst 1 2 3 4 5 6 7 8 9 10 Best**

Place of Employment: _____ Level of Education Completed: _____

Legal Problems/Charges: Include past history, current, and pending charges

| Date | Describe | Outcome (include court dates) | Alcohol/Drug Related |
|---|---|---|---|
| | | | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No |

_____ _____ _____

Signature of person providing information | Date | If other than client, relationship