Nate Sawyer Counseling
4 Round Spring Ln Durham, NC 27712
423-650-9528

Adult Self-Report Form

Name: _____ Date: _____

Address: _____

Best Contact Number: _____ May I leave a message?
(Circle one) Yes No

Date of Birth: _____

Who lives in your home with you?

Name	Age	Gender	Relationship to you

If you need more room, turn to the back page to continue

Chief Concern: What brings you in today??

How do you spend most of your days and nights??

If you are employed outside the home, please say where, your position, and how many hours you put in per week:

Primary Care Provider You See, if any:

Name of provider / practice: _____

Address: _____

Medical Condition	Medications you are taking (Dosage, if known)	How long have you been dealing with this condition??

Past Psychological/Psychiatric Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services? (circle one) Yes No

Please indicate which type of treatment (circle one): Inpatient Outpatient Both

If yes, please indicate:

When:

From Whom:

For What:

Results:

Have you ever taken medications for psychiatric or emotional problems? Yes No

If yes, please indicate:

When

From Whom:

For What:

Type of Medication:

Results:

List of Symptoms

Please circle any of the following that have been bothering you lately:

ABUSED AS CHILD	AGORAPHOBIA	ALCOHOL USE
AMBITION	ANGER	ANXIETY
APPETITE	BEING A PARENT	BOWEL TROUBLE
CAREER CHOICES	CHILDREN	COMPULSIONS
COMPULSIVITY	CONCENTRATION	CONFIDENCE
DEPRESSION	DIVORCE	DRUG USE/ABUSE
EATING PROBLEM	EDUCATION	ENERGY (HI/LOW)
EXTREME FATIGUE	FEARS	FETISHES
FINANCES	FRIENDS	GUILT
HEADACHES	HEALTH PROBLEMS	INFERIORITY FEELINGS
INSOMNIA	LONELINESS	DIFFICULTY MAKING DECISIONS
MARRIAGE	MEMORY	MY THOUGHTS
NERVOUSNESS	NIGHTMARES	OBSESSIVE THINKING
OVER/UNDER WEIGHT	PAINFUL THOUGHTS	PANIC ATTACKS
PHOBIAS	RELATIONSHIPS	SADNESS
SELF-ESTEEM	SEPARATION	SEXUAL PROBLEMS
SHORT TEMPER	SHYNESS	SLEEP
STRESS	SUICIDAL THOUGHTS	WORK
LOSS	SELF HARM	RELIGION / SPIRITUALITY
TRUST ISSUES	FEELING BLAMED	GENDER ISSUES

ADD ANY YOU EXPERIENCE THAT ARE NOT LISTED ABOVE:

_____ _____ _____

PLEASE INDICATE HOW THE ISSUE(S) FOR WHICH YOU ARE SEEKING TREATMENT

are affecting the following areas of your life (circle one for each):

Marriage / Relationship:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Family:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Job/school performance:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Friendships:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Financial situation:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Physical health:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Anxiety level / nerves:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Mood:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Eating habits:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Sleeping habits:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Sexual functioning:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Alcohol / drug use:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Ability to concentrate:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Ability to control anger:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Substance Use

Do you currently use alcohol? Yes No

If yes, on average how many drinks per occasion do you consume?

How many days per week do you consume alcohol?

Do you have a history of problematic use of alcohol? Yes No

Have family members or friends expressed concern about your drinking? Yes No

Do you currently use non-prescribed drugs or street drugs? Yes No

Do you have a history of problematic use of prescription or non-prescription drugs? Yes No

Do you have a family history of alcohol or drug problems? Yes No

If yes, please describe:

Are there events (one time or ongoing) from your past that you feel may contribute to why you are here today??
Say more about that:

What do you see as your strengths?? Give examples if you'd like.

Other

Is there anything else that is important for me as your therapist to know about and that you have not written about on any of these forms? Please tell me here; use the back of the paper if needed.

Thank you for taking the time to fill this out,

Nate