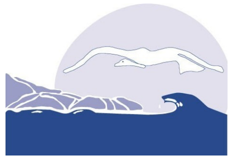

Susan LaFreniere & Associates

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Personal History Updated for: ____________________ Date: _______ DOB: _______ Case #: _____

(Please Print Your Name)

If you need more space for any of the questions please use the back of this sheet.

Primary reason(s) for return to services:

___ Anger management ____ Anxiety ____ Coping ____ Depression
___ Eating disorder ____ Fear/phobias ____ Mental confusion ____ Sexual concerns
___ Sleeping problems ____ Addictive behaviors ____ Alcohol/drugs __ Relational conflict
___ Other concerns : ____

Please check behaviors & symptoms that occur to you more often than you would prefer them to:

___ Aggression
___ Alcohol dependence
___ Anger
___ Antisocial behavior
___ Anxiety
___ Avoiding people
___ Chest pain
___ Cyber addiction
___ Depression
___ Disorientation
___ Distractibility
___ Dizziness
___ Drug dependence
___ Eating disorder

____ Elevated mood
____ Fatigue
____ Gambling
____ Hallucinations
____ Heart palpitations
____ High blood pressure
____ Hopelessness
____ Impulsivity
____ Irritability
____ Judgment errors
____ Loneliness
____ Memory impairment
____ Mood shifts
____ Panic attacks

___ Phobias/fears
___ Recurring thoughts
___ Sexual addiction
___ Sexual difficulties
___ Sick often
___ Sleeping problems
___ Speech problems
___ Suicidal thoughts
___ Thoughts disorganized
___ Trembling
___ Withdrawing
___ Worrying
___ Other (specify): _________
____

Please share any new or updated information since your last visit:

____
____
____

Do you feel suicidal at this time? ____ Yes ___ No

If Yes, explain: ____
____
____

Current prescribed medications	Dose	Frequency	Purpose	Side effects

Current Physician: ______________________________ Phone: ________________