Clinical Interview Form

Date:________________

Name:____SS#____________________

Address:____

City: ___________________________Zip Code:____________________________

Phone Number:____

DOB:________________ Age:___________ Race:__________________________

Languages Spoken:____

Marital Status: ☐ Single ☐ Married ☐ Living Together
☐ Separated ☐ Divorced ☐ Widowed

Number of children:______________ Ages:______________

Education
Highest Grade Completed:_______________ Year:_____ Degree:_____________

Employer/School____________________________ Occupation:_____________

Primary Care Physician:______________________ His/Her Phone #:__________

Insurance Information
Health Plan/Insurance:_______________________ Policy #:________________

Subscriber Name:___________________________ Subscriber SS#____________

Employer:______________________________

Patient Name:___________________________________

Presenting Problem(s)

Please describe your reason for coming in:

____

____

Any recent changes in functioning/mood?

____

____

Difficulty Sleeping? Please describe:

____

____

Difficulty Eating? Please describe:

____

____

How is your mood currently? (Please circle) Cheerful Sad Depressed Apathetic Anxious Restless Calm Angry Frustrated

Habits:

Do you drink alcohol? Yes____ No____ How much per day_____ week_____

Do you use street drugs? Yes____ No____ What type?_______________________

Have you ever sought alcohol/drug treatment? Yes____ No____ When?______

Do you smoke cigarettes? Yes____ No_____ Amount:________________________

Medical History:

Please list any past or present conditions you have been treated for:

____

____

Please list all medications you are currently taking (both prescription and over-the-counter):

____

Patient Name:___________________________________

Have you ever had a head injury?_________________ When?_________________

Loss of consciousness?_____________________ How long?____________________

Psychiatric History:

Have you ever been psychiatrically hospitalized? Yes____ No____

If so, when and where?____

What was the reason for being hospitalized?________________________________

Have you ever been in therapy/counseling in the past? Yes____ No____

If so, when and where? ____

Do you have any history of suicidal ideation? Yes____ No____
If so, when? _______________

Do you have any history of homicidal ideation? Yes____ No____
If so, when?______________

Do you currently have thoughts of wanting to harm yourself? Yes____ No____

Do you currently have thoughts of wanting to harm others? Yes____ No____

Daily Activities

Who do you live with? Family____ Friend____ Alone____ Other____

Which of the following do you do independently? Dress Bathe
Household Chores Errands Shopping
Cook Drive

What outside activities do you have?_____________________________________

What are your hobbies?____

Do you pay your manage your own finance? Yes____ No_____
If not, who does?____