Parkaire Consultants, Inc.

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The information you provide will help us understand your problems and can be released only with your consent.

Date: ______________________ Referred by: ______________________

Client Name: ________________________________ DOB: ____________ Age: ____
Last First Middle

Address: ________________________________ City: ____________

State: ________ Zip: __________ Phone #: ________________ Male: ______ Female: ______

E-mail Address: ________________________________

Emergency Contact: ________________________ Phone #: ________________

In case of emergency, may we call this number?: ❒Yes ❒No

Relationship to you: ________________________________

List all people living in household with client: include siblings, step-children, other relatives, foster children, friends, etc.:

Name	Relationship to Client	Age	Unusual Problems (i.e. coordination, behavior, emotional problems, etc.)

Client's marital status: ❒Single ❒Married ❒Separated ❒Divorced ❒Widowed ❒Partner

Client's employer: ________________________________ Phone: ________________

Diagnosis if available: ________________________________

Please list medications client is currently taking:

Med/Dosage	Condition Requiring Meds	Doctor Who Prescribed Meds	Doctor's Phone	Date Meds Started

Brief Symptom Inventory (BSI)

Using the chart below, how much has each of the following problems distressed or bothered you in the last 7 days including today?

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Faintness or dizziness	0	1	2	3	4
2. Feeling no interest in things	0	1	2	3	4
3. Nervousness or shakiness inside	0	1	2	3	4
4. Pains in heart or chest	0	1	2	3	4
5. Feeling lonely	0	1	2	3	4
6. Feeling tense or keyed up	0	1	2	3	4
7. Nausea or upset stomach	0	1	2	3	4
8. Feeling blue	0	1	2	3	4
9. Suddenly scared for no reason	0	1	2	3	4
10. Trouble getting your breath	0	1	2	3	4
11. Feelings of worthlessness	0	1	2	3	4
12. Spells of terror or panic	0	1	2	3	4
13. Numbness or tingling in parts of your body	0	1	2	3	4
14. Feeling hopeless about the future	0	1	2	3	4
15. Feeling so restless you couldn't sit still	0	1	2	3	4
16. Feeling weak in parts of your body	0	1	2	3	4
17. Thoughts of ending your life	0	1	2	3	4
18. Feeling fearful	0	1	2	3	4
19. Other:	0	1	2	3	4

Have you received any mental health services in the past? ❒No ❒Yes If yes, where? ________________________

What type? ❒Individual Therapy ❒Psychiatric Care ❒Group Therapy ❒ Couples/Family Therapy
❒Outpatient Hospitalization ❒Inpatient Hospitalization

Date began: ____________________ Reason: ____

Was it helpful?: ____

____

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Is the client currently having work/social difficulties? ❒Yes ❒No

If yes, explain: ____

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Please check any special services client has received:

- ❒ LD Resource
- ❒ LD Self-contained
- ❒ BD Resource
- ❒ BD Self-contained
- ❒ MI Resource
- ❒ MI Self-contained
- ❒ MO Self-contained
- ❒ Hearing Impaired Resource
- ❒ Hearing Impaired Self-contained
- ❒ Speech/language Therapy
- ❒ Audiology Services
- ❒ Visual Therapy
- ❒ Occupational Therapy
- ❒ Physical Therapy
- ❒ Adaptive Physical Education
- ❒ Orthopedic Handicapped Services
- ❒ Handicapped Kindergarten
- ❒ Gifted Program
- ❒ Other Health Impaired
- ❒ Remedial Help
- ❒ Tutoring
- ❒ Other: ____

Do you currently drink alcohol?: ❒Yes ❒No

If yes, how often and how much do you drink? ____

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Do you currently use illegal drugs and/or abuse prescription medication?: ❒Yes ❒No

If yes, what kind and how often do you use? ____

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Please give a comprehensive statement of your concerns, listing those of greatest importance first:

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Approximate date the current problem began: ___________________________________

Has the problem gotten worse, gotten better, or stayed the same since it began? Please be specific.

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Please describe any particular disorder or problem that preceded the current difficulty and might have been associated with its onset.

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Who felt the client should be seen at this time? _______________________________

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Printed Name of Client　　　　　　Signature of Client　　　　　　Date

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Printed Name/Credentials of Clinician　　　　　　Signature/Credentials of Clinician　　　　　　Date