TEXAS COUNSELING CENTER

Initial Interview Date: _____ Interviewer: Steven L. Lackey, Ph.D.

Name of Patient: _____ Date of Birth:_____

Patient's Age: _____ Home Phone:_____

Email Address: _____Cell Phone: _____

Patient Address:_____ City_____ State_____ Zip_____

SS #_____ Referring Physician: _____

Work Status

Patient employed by: _____

The patient is employed as a _____

Current Medications:

Medication	**Doctor prescribing**	**Medication**	**Doctor prescribing**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are medications taken as prescribed? □ Yes □ No

Do you take more medications or use more medications than your doctor prescribed? □ Yes □ No

Medical History:

Smoking? □ Yes □ No (describe) _____

Alcohol? □ Yes □ No (describe) _____

Any medical disorders being followed by medical doctor:

_____

Other medical history/surgeries/hospitalizations: _____

_____

For Chronic Pain Patients: The following terms describe the pain: □ constant □ intermittent □ stabbing □ burning □ dull □ sharp □ throbbing □ shooting □ tingling □ aching

On a scale of 1 (lowest) to 10 highest), what is your level of pain today? ____ highest_____ lowest_____

I have received: □ x-rays □ MRI □ physical therapy □ pain injections □ TENs unit □ EMG

I have difficulty with the following activities: □ bending □ walking □ standing □ sitting for too long □ lying in one position for too long □ carrying groceries and other daily chores

Psychosocial History

Family History:

Birth City _____State _____

If patient was not born in the United States, when did patient come to the U.S.? _____

Permanent Resident Alien? □ Yes □ No Citizen? □ Yes □ No

Mother's age: _____ Describe Relationship_____

Father's age: _____ Describe Relationship _____

Were parents divorced? □ Yes □ No □ N/A

If not raised by parents, who raised patient? _____

Patient is the _____ child of _____children.

Number of brothers: _____ Number of Sisters: _____

Are any of patient's siblings deceased? □ Yes □ No Relevant Details:_____

_____

Describe Relationship with Siblings:

_____

Marital/Relationships

Is the patient currently married? □ Yes, □ Separated, □ Divorced, □ Single □ Widow(er)
Currently married for the past _____ years**.**

Previous marriages/length of marriages divorces: _____

_____

Children from current marriage (gender/age): _____

_____

Children from previous relationships (gender/age): _____

_____

Who do you live with? _____

Educational History

High School Graduate? □ Yes □ No □ GED? Date of GED or HS Graduation _____

Years completed in school: _____ Other Education/Educational level _____

Military Service? □ Yes □ No Branch: _____ When? _____Type of discharge: _____

Financial

Where is income coming from now? _____
Is financial situation a major stressor at this time? □ Yes □ No
Stressors related to financial situation: _____

Psychiatric History

Family history of psychiatric treatment or problems? □ Yes □ No

If yes, who and what type? _____

Alcoholism history? □ Yes □ No

If yes, who? _____

Has any relative attempted or committed suicide? □ Yes □ No

If yes, who? _____

Have you ever attempted suicide? □ Yes □ No

If yes, when and circumstances: _____

Any psychiatric inpatient therapy? □ Yes □ No

Where and when: _____

Any psychiatric or substance abuse outpatient therapy? □ Yes □ No

With whom and length of therapy: _____

Any current medications for mood disorders? □ Yes □ No Previously? _____

Check all that apply:

□ Appetite increase/decrease	□ Crying episodes	□ Panic
□ Sadness/Down	□ Motivation decrease	□ Restlessness
□ Hopelessness	□ Helplessness	□ Rapid heart beat
□ Insomnia/Increased sleep	□ Boredom	□ Nervousness/Jittery/Shaky
□ Energy decrease	□ Libido decrease	□ Difficulty breathing
□ Frustration	□ Discouragement about the future	□ Fear of re-injury
□ Irritability	□ Short temper	□ Concentration difficulties
□ Inability to get pleasure out of life	□ Feelings of inadequacy □ Not able to relax	□ Increased concerns about physical health
□ Increased sensitivity, become emotional more easily	□ Muscle tension □ Difficulties adjusting to injury	□ Increased pain with tension or when emotionally upset

What do you worry about the most? _____

Thoughts of suicide? □ Yes □ No Any intent? Any plan? □ Yes □ No

Types of support system: _____