BAILEY BEHAVIORAL HEALTH, LLC

CURRENT CASE HISTORY

Name ____ **Date** ____________________

What is the major problem at present: example, "for the last week or last month I have felt"____

____

Other concerns: ____

____

If this is a recurrence, when was the first time you noticed this problem?_________

____

How did it originally occur?____

____

Has it become worse recently? ___Yes ___No ___Same ___Better

___Gradually Worse If yes, when and how?________________________________

____

How frequent is the condition? ___Constant ___Intermittent

What causes the problem to come on/get worse?_____________________________

____

Are there any other conditions you would like to discuss? ___Yes ___No

If yes, describe: ____

Are there other unrelated health problems? ___Yes ___No

If yes, describe. ____

Is there anything you can do to relieve your major problem? ___Yes ___No

If yes, describe. ____

If no, what have you tried to do that has not helped? _________________________

____

What makes the problem worse? ____

____

NO SYMPTOMS/STRESS	EXTREME SYMPTOMS/STRESS

|____|

Please place an "X" on the line above to indicate level of problem.

____________________	______	____________________	______
Patient's Signature	Date	Parent and/or Guardian	Date

____

Description of Personal Representative's authority

____________________ ______

David Bailey, LCSW Date

Bailey Behavioral Health, LLC

Symptom Check List

(Check Any of the Following that are Problems for You)

__Marriage
__Children
__Parenting
__Work
__Neighbors, Friends
__Own Parents
__Appetite
__Sleep
__Concentration, Forgetfulness
__Fatigue, Tiredness
__Crying Spells
__Depressed Mood
__Suicidal Thoughts
__Loss of Interest in Pleasure
__Hopelessness
__Irritability, On Edge
__Headaches
__Stomachaches, Nausea
__Hyperventilation
__Difficulty Breathing
__Heart Racing, Pounding
__Dizziness, Lightheadedness
__Sweating, Hot Flashes, Chills
__Trembling, Shaking
__Tingling, Numbness
__Gambling
__Spending Money
__Stealing, Shoplifting
__Lying
__Self Inflicted Cuts, Scratches
__Suicide Attempts
__Can't Stop Talking
__Afraid to Leave Home or Go in Public Places
__Physical or Sexual Abuse
__Nightmares
__Guilt, Self Blame
__Anger Outbursts
__Loss of Memory for Parts of Past
__Trusting Others
__Suspicious of Others
__Afraid of Being Criticized by Others
__Self Esteem
__Sex
__Excessive or Unrealistic Fears
__Constant Worry
__Weight
__Body Image
__Problems Eating or Vomiting
__Preoccupation with Details, Lists, Order, etc.
__Compelled to Do the Same Thing Over and Over
__Recurring Thoughts which You Can't Rid
__Fear of Dying, Losing Control, or Going Insane
__Ideas Racing Through Your Head
__Difficulty Saying "No" to Others
__Letting Others Take Advantage of You
__Abusive Relationship
__Take Your Anger Out on Others Verbally and Physically
__Super Energy Like You Could Do Anything
__Drink Alcohol Too Much
__Use Drugs Too Much
__Unable to Stop Using Alcohol or Drugs
__Withdrawal from Alcohol or Drugs