Welcome to Torrey Hills Health

Client Information

1. What are the current problems you are experiencing?

_____

_____

_____

2. How long have the problems been occurring, when did they first begin?

_____

_____

3. Have there been any major changes lately? Yes No If yes, please explain below.

_____

_____

_____

4. Are you currently receiving any treatment? Yes No If yes, please answer below.

Where is the current place of treatment? _____

_____

5. Have you received any previous treatment? Yes No If yes, please answer below.

What were the reason(s) for the treatment? _____

_____

_____

6. Have you currently or ever been prescribed any psychotropic medication? Yes No If yes, please list type, amount, frequency and date last used below:

_____

_____

7. Are you currently experiencing any thoughts of self harm? Yes No

8. Are you currently experiencing any thoughts of harm to others? Yes No

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9. Are you currently exhibiting any of the following symptoms?

Fatigue	Yes	No	Hearing Voices	Yes	No	Seeing things	Yes	No
Lying	Yes	No	Bowel Problems	Yes	No	Stomach Problems	Yes	No
Worries	Yes	No	Appetite Changes	Yes	No	Difficulty Sleeping	Yes	No
Anxiety	Yes	No	Mood Changes	Yes	No	Poor Concentration	Yes	No
Hyperactivity	Yes	No	"Sleep Walking"	Yes	No	Nightmares/Bad Dreams	Yes	No
Stealing	Yes	No	Unusual Fears	Yes	No	Frequent Anger Outbursts	Yes	No
Opposition	Yes	No	Truancy	Yes	No	Fire Setting	Yes	No
Impulsiveness	Yes	No	Inattentiveness	Yes	No	Memory Problems	Yes	No
Rapid Heartbeat	Yes	No	Racing Thoughts	Yes	No	Flashbacks	Yes	No

For those you answered "Yes", please explain more details below.

_____

_____

_____

_____

_____

10. Any difficulty with work or school? Yes No If yes, please explain below.

_____

_____

_____

_____

11. Any difficulty with family, friends /relationships? Yes No If yes, please explain below.

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_____

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12. Any police /probation involvement? Yes No If yes, please explain below.

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_____

12. Any health concerns? Yes No If yes, please explain below.

_____

_____

_____

13. Any drug or alcohol use? Yes No If yes, please explain below. Include type, amount, frequency and date last used as well as previous treatment, if any.

_____

_____

14. Any family history of psychiatric illness /treatment? Yes No If yes, please explain below.

_____

_____

15. Please list below any other concerns or stressors you may have not covered in the intake form:

_____

_____

_____

I consent to be treated as a client by Angela L. Phillips, M.A., L.M.F.T..

_____ _____

Print Name Signature Date

_____ _____

Print Name Signature Date

_____ _____

Provider Name Signature Date