PSYCHOTHERAPEUTIC RESOURCES

CLINICAL UPDATE FORM

Name_____ Today's Date _____

DOB: _____ Race: _____

What would you like therapy to help you change:_____
_____
_____
_____

In an effort to coordinate care, we would like to obtain/give information from previous providers and/or your referral source. With your written authorization, we will be informing your physician (by letter) of your diagnosis and care here, communicating (as necessary) with your referring agent and requesting past mental health records.
Please check: **YES**, and provide us with the names and addresses needed to prepare the authorization form(s) or check **No** if not necessary at this time.

Primary Care: _____ **Yes ____ No____***

Referral Source: _____ **Yes ____ No____***

Past Mental Health: _____ **Yes____ No____***

Are you experiencing, or have you experienced, since your last Psychotherapeutic Resources visit on _____ any of the following stressors? (Y=Yes, N=No, DK= Don't know).

Financial	Y	N	DK
Primary relationship (family/friends)	Y	N	DK
Housing	Y	N	DK
Physical health of self or family member	Y	N	DK
Access to health care	Y	N	DK
Occupation/employment	Y	N	DK
Legal	Y	N	DK
Education	Y	N	DK
Other_____			

Current Medical Care

Physician_____

Medical Diagnosis _____
_____

Medications/Dosage_____

What type of exercise do you get?_____Frequency_____

Since your last treatment here, have you seen another outpatient counselor, been in inpatient treatment, or seen a psychiatrist? **Yes** **No**
If yes, who & where?_____
_____
_____

Current Use of Alcohol/Drugs

Circle average weekly alcohol intake: None 1-3 drinks 4-8 drinks More than 8
Circle recreational/mood enhancing nonprescription drug use: None Daily Weekly Monthly
Circle Type of Drug Used: Cannabis Cocaine Painkillers Speed Methamphetamine
Other_____

In the last year have you experienced any of the following:

Picked up or charged with a drug-related driving offense?	Y N DK
Lost time from school or work because of use?	Y N DK
Experienced a medical problem because of use?	Y N DK
Been fired from a job because of use and its effects?	Y N DK
Felt you ought to cut down on your drinking or drug use?	Y N DK
Had people annoy you by criticizing your drinking or drug use?	Y N DK
Felt bad or guilty about your drinking or drug use?	Y N DK
Had a drink or used drugs as an eye opener first thing in the morning to steady your nerves or get rid of a hangover, or to get the day started?	Y N DK

My average daily nicotine use is: _____

My average daily caffeine use is: _____

After filing out the previous chart, circle the difficulty level these problems have created for:

Work

Not difficult at all Somewhat difficult Very difficult Extremely difficult

Taking Care of Things at Home

Not difficult at all Somewhat difficult Very difficult Extremely difficult

Getting Along With Others

Not difficult at all Somewhat difficult Very difficult Extremely difficult