PSYCHOTHERAPEUTIC RESOURCES

CLINICAL UPDATE FORM

Name:____ Date:_____________

DOB:______________ Age: ______ Preferred Name:__________ Preferred Pronoun(s):___________

Ethnic Origin: ____________ Sexual Orientation: _____________ Gender/Gender Identity:_________

Current City: _________________________________

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

Do you use alcohol? Y N

How many days per week? _______ How many drinks per day? ______

Do you use any of the following?

Cannabis/Marijuana ____

Cocaine ____

Methamphetamines ____

Opiods/Heroine ____

Other_____________

How many days per week? ______ How much each day? ______

Have you experienced any of the following:

	In the last year	In your lifetime
Picked up or charged with a drug-related driving offense?	Y N DK	Y N DK
Lost time from school or work because of use?	Y N DK	Y N DK
Experienced a medical problem because of use?	Y N DK	Y N DK
Been fired from a job because of use and its effects?	Y N DK	Y N DK
Felt you ought to cut down on your drinking or drug use?	Y N DK	Y N DK
Had people annoy you by criticizing your drinking or drug use?	Y N DK	Y N DK
Felt bad or guilty about your drinking or drug use?	Y N DK	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	Y N DK

Do you use nicotine? Y N

How many days per week? _____ How much each day? _____

Do you drink caffeine? Y N

How many days per week? _____ How much each day? _____

Past Use of Alcohol/Drugs

Has alcohol or drugs caused any problems for you in the past? Y N

If yes, what kind of problems?

____

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: ___________________________ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**________

If this questionnaire is completed by an informant, **what is your relationship with the individual?** ___________________
In a typical week, approximately how much time do you spend with the individual? ____________________ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

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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