PSYCHOLOGY CENTER
7441 0 STREET SUITE 402
LINCOLN, NE 68510

SUPPLEMENTAL PERSONAL DATA SHEET

What is happening in your life which resulted in this appointment?
____
____

What would you like to see accomplished in therapy?
____
____

CHIEF COMPLAINT (CHECK ALL THJAT APPLY TO YOU):

__ Depression
__ Low energy
__ Low self-Esteem
__ Poor Concentration
__ Hopelessness
__ Worthlessness
__ Guilt
__ Sleep disturbance (more/less)
__ Appetite disturbance (more/less)
__ Thoughts of hurting yourself
__ Thoughts of hurting someone
__ Isolation/social withdrawal
__ Sadness/loss
__ Stress
__ Anxiety/panic
__ Heart pounding/racing
__ Chest Pain
__ Trembling/shaking
__ Fear of dying
__ Fear of going crazy
__ Nausea
__ Chills/hot flashes
__ Phobias
__ Thoughts racing
__ Easily agitated
__ Delusions
__ Other Problems/symptoms
__ Feeling that you are not real
__ Feeling that things around you aren't real
__ Blackouts
__ Lose track of time
__ Unpleasant thoughts won't go away
__ Nightmares
__ Anger/frustration
__ Easily agitated/annoyed
__ Defies rules
__ Blames others
__ Argues
__ Excessive use of drugs and/or alcohol
__ Excessive use of prescription drugs
__ Physical abuse issues
__ Sexual abuse issues
__ Spousal abuse issues
__ Employment difficulties
__ Marital/relationship problems
__ Medical/Health problems
__ Legal concerns
__ Sweating
__ Tingling/numbness
__ Obsessions/compulsive behaviors
__ Can't hold onto an idea
__ Excessive behaviors (spending/gambling)
__ Not thinking Clearly/Confusion

Previous outpatient therapy? ____ Yes ____ No, with _________________

What was accomplished? ____

Medications, list: ____

Previous hospitalization? _____ Yes _____ No

Number of hospitalizations ____ ECT? _______ If yes, when_____________