Janet B. Reigel, Psy.D.
2106 NE 40th Portland, Oregon 97212
jbreigel@msn.com | 503 335 8038
http://www.janetbreigel.com

Self-Assessment

What is happening in your life that brought you to this appointment? Please describe:

CHIEF COMPLAINTS (CHECK ALL THAT APPLY TO YOU & ADD COMMENTS AS NEEDED):

___Depression:
___Low Energy:
___Poor self-image:
___Poor concentration:
___Hopelessness:
___Guilt:
___Worthlessness:
___Sleep disturbance: More ___ Less___
___ Appetite disturbance: More___ Less ___
___Thoughts of hurting yourself:
___Thoughts of hurting someone else:
___Isolation/social withdrawal:
___Grief/loss:
___Discouragement:
___Fatigue: Please describe:
___Indecisiveness:
___Irritability:
___Loss of interest in life:
___Loss of motivation:
___Loss of libido:
___Worry about health: Please describe:
___Worry:
___Difficulty controlling worry:
___Specific fears:
___Feeling detached or foggy: Please describe:
___Sense of impending doom:
___Unexpected panic attacks:
___Panic with specific situation/circumstances:
___Muscle tension:
___Tingling or numbness in toes or fingers
___Stomach upset or butterflies:
___Nausea:
___Restlessness/Jumpiness:
___Difficulty Concentrating:
___Racing thoughts:
___Frightening dreams or daydreams: Please explain:
___Fears of abandonment or being alone:
___Hot flashes not brought on by heat:

___Trembling or shaking:
___Rubbery or "jelly" legs
___Dizziness/light headedness:
___Difficulty breathing:
___Fear of criticism or disapproval:
___Fear of dying:
___Obsessive thoughts:
___Compulsive behaviors: Please explain:
___Losing track of time:
___Blackouts:
___Excessive use of alcohol or drugs:
___Excessive behaviors other than alcohol/drugs: Please explain:
___Pattern of arguing:
___Agitation:
___Physical abuse:
___Abuse history:
___Current abuse:
___Relationship problems:

___Employment conflicts:
___Vocational planning needs:
___Recent termination from employment
___Employment coaching needs:

Other problems/symptoms: (Please explain.)

____
____
____

Brief Medical History

Name: ______________________________ Age: __________ DOB: __________

Primary Care Phsician: ______________________________

Last medical exam: ______________________________

List medical problems that you are currently experiencing or being treated for:

____
____

Physician monitoring the above condition(s): ______________________________

List any medications currently taken:

____
____

Who prescribed the medications?

____

____

Do you currently experience physical pain? ____________ If yes, pleased explain: _____________

____

PLEASE CHECK ANY OF THE FOLLOWING THAT MAY APPLY:

__Lack of appetite:

__Excess use of alcohol/drugs:

__Headaches:

__Sexual concerns:

__OB/GYN concerns

__Stomach/gastric distress:

__Muscle tightness