SAN DIEGO
BEHAVIORAL MEDICINE

CLINICAL INFORMATION

Name: _____ Date: _____/_____/_____
Last, First

Chief Concern
Please describe the major concern(s) you would like psychological services to help with:

_____

_____

_____

How long have you been dealing with the problem(s)? _____

What made you decide to seek help now? _____

_____

Who felt you should seek treatment? (check all that apply): ☐ Myself ☐ Friend ☐ Family Member ☐ Employer

☐ Physician (name): _____ ☐ Other: _____

What do you hope to get from psychological services? _____

_____

Quality of Life
Please rate your current overall health by marking an X on the line below:

|----------|
Terrible Excellent

Please rate your ability to perform daily activities (dressing, house chores, errands, etc.) during the past week by marking an X on the line below:

|----------|
Terrible Excellent

Who or what makes it harder for you to cope with your difficulties(s)? _____

_____

What do you do for relaxation? _____

Who or what helps you cope with your difficulties(s)? _____

_____

Previous Psychological Treatment

Dates	Reason	Outcome (Note if positive, negative, neutral)

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