Instructions for provider: Share this form with patients before their first appointment. Collect and review before the session.

1. PATIENT INFORMATION

First name | Last name

Date of birth (MM/DD/YYYY) | Phone number

Email address

2. PRESENTING CONCERN

Primary concern — what brings you in today? *

Duration of concern | Functional impact on daily life (circle: 0–1–2–3–4–5–6–7–8–9–10)

What prompted you to seek care now?

Treatment goals — what are you hoping to achieve?

3. MOOD & EMOTIONAL EXPERIENCE

Select anything that has felt true for you recently:

☐ Low mood ☐ Loss of pleasure ☐ Anxiety ☐ Panic ☐ Irritability
☐ Racing thoughts ☐ Detachment ☐ Unusual thoughts ☐ Compulsions

Current mood state (circle: Mostly low / Fluctuating / Stable / Elevated) | Persisted > 2 weeks? (Yes / No)

Mood improves with positive events? (Yes / No) | Excessive anxiety? (Yes / No)

4. FUNDAMENTAL FUNCTIONS

Sleep patterns — select anything true recently:

☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Early waking
☐ Oversleeping ☐ Irregular schedule ☐ No issues

Hours of sleep per night (circle: <4 / 4–6 / 6–8 / 8+) | Appetite changes (circle: Decreased / Increased / No change)

Energy patterns — select anything true recently:

☐ Low energy ☐ Fatigued ☐ Variable energy ☐ High energy ☐ No concerns

5. FOCUS & THINKING

Difficulty focusing or staying on task? (Yes / No)	Concentration baseline (circle: Stable / Diminished / Extraordinary / Unsure)

6. CHANGES IN MOOD PATTERNS

Decreased need for sleep but still energetic? (Yes / No)	Unusually elevated or energized mood? (Yes / No)
Increased drive or productivity? (Yes / No)	Out-of-character risk-taking? (Yes / No)
Rapid speech or pressure to talk? (Yes / No)	Acting more on impulse than usual? (Yes / No)

7. CURRENT STRESSORS

Select anything currently applicable:

☐ Work / school	☐ Relationship	☐ Financial
☐ Housing	☐ Legal	☐ Social isolation

8. SUBSTANCE USE

Judgment-free. Honest answers help your clinician support you best.

Alcohol (circle: None / Occasionally / Weekly / Daily)	Cannabis (circle: None / Occasionally / Weekly / Daily)
Natural stimulants — coffee, energy drinks (None / Occ / Weekly / Daily)	**Prescription stimulants (None / Occasionally / Weekly / Daily)**
Opioids (circle: None / Occasionally / Weekly / Daily)	**Other substances (circle: None / Occasionally / Weekly / Daily)**

9. SAFETY — REVIEW CAREFULLY BEFORE APPOINTMENT

Thoughts of not wanting to be alive? (Yes / No)	If yes — how often? (Fleeting / Frequent / Persistent)
Thoughts of harming yourself or ending your life? (Yes / No)	Thought about a specific method? (Yes / No)
Currently have a plan? (Yes / No)	Intent to act on this plan? (Yes / No)
Taken any preparatory steps? (Yes / No)	Thoughts of harming someone else? (Yes / No)
Specific person identified? (Yes / No)	Homicidal plan? (Yes / No)

10. HEALTH & TREATMENT BACKGROUND

Chronic medical conditions	Current medications

Current supplements (vitamins, herbs, OTC products, performance enhancers)

Psychiatric medications in past 12 months? (Yes / No)	If yes — experience (circle: Helpful / Not helpful / Side effects)

Additional notes