AR Psychiatric And Counseling Center

Follow Up Information

Patient Name _____ **Date**_____

DOB_____

Changes in symptoms since the last visit:

- ☐ Unchanged/persisting
- ☐ Improving
- ☐ Worse
- ☐ Resolved

Severity of Symptoms:

- ☐ Mild
- ☐ Moderate
- ☐ Severe

Current Stresses

- ☐ Financial
- ☐ Marital
- ☐ Family
- ☐ Health
- ☐ Job
- ☐ School

Current symptoms present are:

- ☐ Depressed mood
- ☐ Loss of interest in things
- ☐ Tiredness
- ☐ Sleep disturbance
- ☐ Change in appetite
- ☐ Lack of motivation
- ☐ Irritability/ Anger
- ☐ Lack of concentration
- ☐ Indecisiveness
- ☐ Feelings of worthlessness
- ☐ Suicidal thoughts
- ☐ Self mutilation
- ☐ Nightmares
- ☐ Flashbacks of past trauma or abuse
- ☐ Excessive worrying
- ☐ Inability to relax
- ☐ Muscle tension
- ☐ Anxiety attacks
- ☐ Nervousness
- ☐ Apprehension
- ☐ Obsessive thinking
- ☐ Compulsive behaviors
- ☐ Fears or phobias
- ☐ Hallucinations
- ☐ Paranoid feelings
- ☐ Impulsive behaviors
- ☐ Poor memory
- ☐ Bingeing
- ☐ Purging
- ☐ Elevated mood or grandiosity
- ☐ Decreased need for sleep (feeling rested after few hours of sleep)
- ☐ Unusual talkativeness
- ☐ Racing thoughts
- ☐ increased activity level or agitation
- ☐ buying sprees
- ☐ sexual indiscretions
- ☐ foolish business investments
- ☐ Other reckless behaviors

Have you been taking your medications as prescribed? Yes ( ) No ( ) Sometimes ( )

Do you have any **chronic pain**? Yes ( ) No ( ) **Where** ? _____

How severe is the pain **(0n 1-10 scale, 1 no pain, 10 worst pain)**_____

Are you **receiving any treatment for pain**? Yes ( ) No ( )_____

Have you used any **alcohol and drugs** (illegal and narcotics) since the last session? Yes ( ) No ( )

Any **side effects** from medications?_____

_____

Any **changes or additions** to your medications? Yes ( ) No ( )_____

_____

_____

OTHER CONCERNS:_____

_____

_____

_____

_____

Signature:_____

Please check mark any of the physical symptoms present:

General:

- ☐ Weight loss
- ☐ Weight gain
- ☐ Decrease in appetite
- ☐ Increase in appetite
- ☐ Fever or chills
- ☐ Fatigue
- ☐ Trouble sleeping

Skin-

- ☐ Rashes
- ☐ Itching
- ☐ Dryness

Ears

- ☐ Ringing in ears
- ☐ Earache
- ☐ Drainage

Eyes-

- ☐ Blurry or double vision

Nose

- ☐ Stuffiness
- ☐ Discharge
- ☐ Itching

Throat-

- ☐ Dry mouth
- ☐ Sore throat
- ☐ Hoarseness

Respiratory-

- ☐ Cough
- ☐ Sputum
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing

Cardiovascular-

- ☐ Chest pain or discomfort
- ☐ Tightness
- ☐ Palpitations
- ☐ Shortness of breath

Gastrointestinal-

- ☐ Swallowing difficulties
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Rectal bleeding

Genito-Urinary-

- ☐ Frequency
- ☐ Urgency
- ☐ Burning or pain
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Delayed ejaculation
- ☐ orgasm problems
- ☐ Decreased sex drive
- ☐ Erectile issues

Musculoskeletal-

- ☐ Muscle or joint pain
- ☐ Stiffness
- ☐ Back pain
- ☐ Swelling of joints

Neurologic-

- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Headache
- ☐ Numbness
- ☐ Tingling
- ☐ Tremor
- ☐ Memory problems

Hematologic-

- ☐ Ease of bruising
- ☐ Ease of bleeding

Endocrine-

- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Sweating
- ☐ Frequent urination
- ☐ Increased thirst

Breasts-

- ☐ Lump
- ☐ Pain
- ☐ Discharge