Michael S. Trieger, Psy.D.
Licensed Clinical Psychologist

Melissa Fisher Paoni, Ph.D.
Licensed Clinical Psychologist

Lori K. McKenzie, Psy.D.
Licensed Clinical Psychologist

Bill McKenzie, MA, LCPC
Licensed Clinical Professional Counselor

Greg Irwin, LCPC
Licensed Clinical Professional Counselor

Jeanette Hoelzer, LCPC
Licensed Clinical Professional Counselor

Bethany Bilyeu, Psy.D.
Licensed Clinical Professional Counselor

Kelsie Tobias, LCSW
Licensed Clinical Social Worker

Springfield Psychological Center, LLC

ADULT HISTORY

Name: _____ Nickname: _____ Pronouns: _____

Address: _____ City: _____ Zip: _____

Phone #: _____ Work #: _____

DOB: _____ Age: _____ Occupation: _____

Referred by? _____

Reason for making appointment? _____

_____

With whom are you now living? (list people):

Name	Age	Relationship	Occupation
_____			
_____			
_____			
_____			

Medical History (include past and present conditions): _____

_____

Medications: _____

_____

Primary Physician: _____

Previous Mental Health Treatment

When?	With Whom?	Outcome
_____		

Any prior mental health hospitalizations: _____

_____

_____

3416 Liberty Drive ● Springfield, IL 62704 ● (217) 793-3949 ● FAX (217) 793-3995

Family History of mental or emotional problems, including alcohol or substance abuse:

_____

_____

Educational History (Briefly describe school experiences, including highest grade level attained.)

_____

_____

Employment History

1. Present employment status and where: _____

_____

2. Work related concerns? _____

_____

Talents and skills: _____

Symptom Check List **(check all that apply to you):**

___Depression	___Feeling that you are not real	___Lose track of time
___Low energy	___Anger control problems	___Defies rules
___Poor concentration	___Blames others	___Argues
___Hopelessness	___Alcohol/drugs	___Blackouts
___Worthlessness	___ Stomach/bowel problems	___Headaches
___Guilt	___Spousal abuse	___Sadness/loss
___Anxiety/panic	___Heart pounding/racing	___Chest pain
___Trembling/shaking	___Chills/hot flashes	___Sweating
___Tingling/numbness	___Phobias	___Racing thoughts
___Nausea	___Delusions/hallucinations	___Relationship issues
___Confusion	___Sleep disturbance (more/less)	___Intrusive thoughts
___Self-injury	___Loneliness	___Marital/family
___Dizziness	___Impulse control problems	___Social withdrawal
___Nightmares	___Thoughts of hurting yourself (past/present)	
___Physical abuse (past/present)	___Thoughts of hurting others (past/present)	
___Sexual abuse (past/present)	___Appetite disturbance (more/less)	
___Excessive behaviors (spending/gambling/sex)		
___Other (specify)_____		

_____ _____

Date Signed
(Patient/Guardian)