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

Melissa Fisher Paoni, Ph.D.
Licensed Clinical Psychologist

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

Donald R. Henke, LCSW
Licensed Clinical Social Worker

Springfield Psychological Center, LLC

Bill McKenzie, MA, LCPC
Licensed Clinical Professional Counselor

Jenna Reid Yates, Ph.D.
Licensed Clinical Psychologist

Greg Irwin, LCPC, ALMFT
Licensed Clinical Professional Counselor

Jeanette Hoelzer, LCPC
Licensed Clinical Professional Counselor

ADULT HISTORY

Name: _____ Date: _____

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: _____
_____

Physician: _____
Previous Mental Health Treatment
When? With Whom? Outcome

_____

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

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

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 ___Appetite disturbance (more/less) ___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) ___Stomach/bowel problems
___Excessive behaviors (spending/gambling/sex)
___Other (specify)_____

_____ _____

Date Signed
(Patient/Guardian)