Name:_____Date of Office Session:_____
Name(s) of Provider(s) seen since last session (therapists, medical doctors, etc.):

_____
Medication Changes:_____

_____
Medication Side Effects:_____

_____
Current Medical Problems:_____

Please rate **Active Symptoms** since last session
Blank=Not a problem 1=Some Problem 2=Major Problem

___ Too Little Sleep	___ Self-Blame	___ Worries about the Future
___ Too Much Sleep	___ Irritability	___ General Anxiety
___ Decreased Need for Sleep	___ Concentration	___ Physical Symptoms of Anxiety
___ Drowsiness	___ Memory	___ Social Anxiety
___ Too Little Appetite	___ Racing Thoughts	___ Panic Attacks
___ Too Much Appetite	___ Rapid Speech	___ Overusing Substance(s)
___ Low Energy	___ Restlessness	___ Thoughts of Death
___ Excess Energy	___ Acting Without Regard for Consequences	___ Suicidal Thoughts
___ Too Sad for Circumstances	___ Overspending	___ Homicidal Thoughts
___ Too Happy for Circumstances	___ Distractability	___ Thoughts that Repeat Themselves Over & Over
___ Low Interest in Activities	___ Disorganization	___ Behaviors that Repeat Themselves Over & Over
___ Excess Interest in Activities	___ Regrets about the Past	___ Thoughts of Causing Physical Pain to Yourself

Other Symptoms that may effect your medication. Please be to the point and prioritize:

1.

2.

3.

Questions:

Would you like Dr. Dorfman to print out a list of the medications she prescribes for you?