Saurabh Gupta, MD

Tel: (302) 478 6100
www.drguptamd.com
childmind@gmail.com

Initial or Follow Up focused review : ADULTS

Patient Name _____ *Date_____*

DOB_____

Changes in symptoms since the last visit:

Current symptoms present are:

□ *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* □ *Feelings of worthlessness*
□ *Depressed mood* □ *Loss of interest in things* □ *Tiredness*
□ *Sleep disturbance* □ *Change in appetite*
□ *Lack of motivation* □ *Irritability/ Anger* □ *Lack of concentration* □ *Indecisiveness*
□ *Suicidal thoughts* □ *Self mutilation*
□ *Nightmares* □ *Flashbacks of past trauma or abuse*

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 ( )_____
_____
_____
Current Stresses
□ *Financial* □ *Marital* □ *Family* □ *Health* □ *Job* □ *School*

OTHER CONCERNS:_____

_____