Nancy J. Simons, Ph.D.

Clinical Assessment Form

Name________________________________

Current psychotropic medication____

New medical issues or exacerbation of existing ones affecting how you feel emotionally__________
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New social, emotional, family or employment issues affecting you___________________________
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Current
Symptoms____

Symptom		Symptom	
Lowered mood	O	Impaired memory	O
Tearfulness	O	Feelings of Hopelessness	O
Decreased energy	O	Suicidal thinking	O
Decreased interest and motivation	O	Excessive Energy	O
Social withdrawal	O	Anxiety	O
Change in appetite	O	Panic Attacks	O
Sleep disturbance	O	Excessive worry	O
Mental clouding	O	Hallucinations	O
Agitation	O	Delusions	O
Irritability	O	Homicidal ideations	O
Impaired Concentration	O	Other______________________	

ADLs_____________________ Eye Contact_______________ Orientation______________________

Diagnosis____

Goals____
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Treatment____

Return Appointment________________________________

Provider Signature___________________________ Date__________________ Time____________