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Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Medications and dose: \_\_\_\_\_  
\_\_\_\_\_

Session Length: \_\_\_23-30 min. X37-45 min. \_\_\_53-60 min. \_\_\_Other \_\_\_\_\_  
**Sleep:** \_\_\_Good \_\_\_Poor \_\_\_Nightmares    **Appetite:** \_\_\_Good \_\_\_Poor  
**Energy:** \_\_\_Good \_\_\_Poor \_\_\_Hyperactive    **Stress Tolerance:** \_\_\_Good \_\_\_Poor  
**Weight:** \_\_\_Gained > 5 lbs. \_\_\_Lost >5 lbs.    **Irritability:** \_\_\_Up \_\_\_Down \_\_\_wnl  
**Anger Probs:** \_\_\_Up \_\_\_Decreased \_\_\_None    **Crying Spells** \_\_\_Up \_\_\_Down \_\_\_None  
**Interest:** \_\_\_Good \_\_\_Poor    **Motivation:** \_\_\_High \_\_\_Low \_\_\_wnl

Have you been thinking about suicide? \_\_\_yes \_\_\_no.  
Do you have a plan to end your life? \_\_\_yes \_\_\_no  
Do you "cut" yourself in any way? \_\_\_yes \_\_\_no

Hallucinations? \_\_\_ (Y or N) Delusions? \_\_\_ Y or N  
Do you have problems concentrating or focusing? \_\_\_yes \_\_\_no  
Have you been feeling down? \_\_\_yes \_\_\_no  
Rate on a scale of 1-10, with 10 being very depressed. \_\_\_\_\_  
Have you been feeling anxious? \_\_\_yes \_\_\_no  
Rate on a scale of 1-10, with 10 being very anxious. \_\_\_\_\_  
Panic attacks? \_\_\_yes \_\_\_no  
Have you had any changes in your health? \_\_\_\_\_  
\_\_\_\_\_

Do you need me to contact your PCP? \_\_\_yes \_\_\_no Telephone: \_\_\_\_\_  
**YOU MAY STOP HERE.**

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Diagnosis: SAME? \_\_\_\_\_  
Axis I: \_\_\_\_\_ Axis IV: \_\_\_Mild\_\_\_Moderate\_\_\_Severe  
Axis II: \_\_\_\_\_ Axis V: GAF: \_\_\_\_\_  
Axis III: \_\_\_\_\_  
Patient Compliant? \_\_\_yes \_\_\_no Grooming? \_\_\_Good \_\_\_Poor  
GOALS: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature