ANXIETY DISORDERS

AGENT NAME: ____

CLIENT NAME: ____ **Date:** ____________________

1. Date of diagnosis: ____________________________

2. ☐ Generalized anxiety disorder ☐ Panic disorder

   ☐ Obsessive compulsive disorder ☐ Post-traumatic stress syndrome

   ☐ Agoraphobia ☐ Other anxiety disorder ____

3. Indicate the number of episodes and date of last episode/recovery: _________________________

4. Is client on any medications: ☐ No ☐ Yes; please provide name and dosage ____

5. Has client been hospitalized or seen in the emergency room for treatment of anxiety or other psychiatric illness? ☐ No ☐ Yes, please give dates and lengths of stay. ____

6. Does client have a history of any of the following associated conditions? (check all that apply)

   ☐ Depression ☐ Suicidal thought/attempt

   ☐ Substance abuse (alcohol or drugs) ☐ Other psychiatric disorder ____

7. Is the client currently working? ☐ No ☐ Yes (occupation)____

8. Has any time been lost from work as a result of condition? ☐ No ☐ Yes; please give full details

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9. Please list current medications (including aspirin), (accurate name, dosage, and reason):

(Accurate) Name of Medication	Dosage	Reason

10. Are there any other health issues? (additional questionnaires may be required) ☐ No ☐ Yes; please give details

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