

SAMPLE IDEA

INTERVAL HISTORY FORM

Client / Patient Name:

Date of Visit:

SINCE YOUR LAST VISIT:

- Any Changes in Address/Phone Number(s)/Living Status:

- Any Emotional or Physical Traumas:

- Describe any insights you've gained:

- Changes in Medications:

- Changes in General Health:

- Medical Care Received:

ANY SPECIFIC REACTIONS FROM YOUR LAST VISIT:

Overall since my last I am: (circle one) BETTER NO CHANGE WORSE

Current emotional well-being: (10 being BEST)

1 2 3 4 5 6 7 8 9 10

Current family life:

1 2 3 4 5 6 7 8 9 10

Current Work Life:

1 2 3 4 5 6 7 8 9 10

PROBLEM LIST:

- 1.
- 2.
- 3.
- 4.

For physical exercise, I have:

Is there anything else you'd like your clinician to know today?

What particularly would you like to discuss today:

How would you describe the need for today's visit?

Without today's visit I would be...