

STRESS FORM

Robbins Headache Clinic

Name: _____ Date: _____

How did you hear about the practice? _____

If referred, name & phone number of referring physician: _____

Do you have any siblings? Names and ages (if applicable)

Describe briefly (personality traits, medical problems, etc.):

Father: _____

Mother: _____

List several traits which best describe your personality: _____

History of clinical/counseling intervention: Yes No

If yes, was it *Inpatient* or *Outpatient* (circle one) Dates: _____ Currently ongoing: Yes No

Primary Therapist was/is: (circle one) Psychiatrist Marriage Counselor Psychologist Social Worker

Other (Please describe) _____

Primary reason for seeing the above: _____

(Turn page over)

Current areas in which I am under stress include the following: (circle all that apply)

Work

Marriage

School

Financial Pressure

Time Management

Relationship/Interactions w/ parents

Relationship/Interactions w/ children

none of the above

other (please list below)

Please elaborate briefly on any items checked above: _____

Please note if any of the following apply to you: you may elaborate briefly on any that apply

History of alcoholism in family _____

Emotional abuse as a child _____

Physical abuse as a child _____

Early or recent head injury _____

Suicidal thoughts (past or present) _____

Friends and family members do not understand or appreciate the nature of your headaches:
