**Personal Information:**

Name: First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I. \_\_\_\_\_\_ Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: [ ]  M [ ]  F

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_
 Street City State Zip code

Phone: Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_ Social Security # \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Information:**

Name: First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I. \_\_\_\_\_\_ Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_
 Street City State Zip code

Relationship to You:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

Marital Status: [ ]  Single [ ]  Married [ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment Status: [ ]  Employed [ ]  Full-time Student [ ]  Part-time Student [ ]  Retired

Is your condition related to: [ ]  Employment? [ ]  Auto Accident? State \_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Other Accident

Will your treatment be covered by an EAP Program? [ ]  No [ ] Yes: EAP/Contact Person:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you under your employer's health plan? [ ] No [ ]  Yes: Employer's Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy Holder:** (if policy holder is the client listed above, check here [ ]  and skip to ***\*\****)

Name: First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I. \_\_\_\_\_ Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: [ ]  Male [ ]  Female

Phone: Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_
 Street City State Zip code

Insured date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS# of insured: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Relationship to client: [ ]  Spouse [ ]  Parent [ ]  Other

***\*\*If you are covered under another Health Benefit Plan,***

***please fill out another cover sheet and write "Secondary Insurer" on the top of the form.***

**Individual’s or Authorized Person's Signature:** I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party below:

**Signed** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insured or Authorized Person's Signature:** I authorize payment of medical benefits to the Counseling and Wellness Center for services:

**Signed** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Thank you for your patience and cooperation in completing this form. Your responses will help us make effective use of our first session together.***

***-- The Counseling & Wellness Center Office Team and Practice Colleagues***

**[ ]** I received the Counseling & Wellness Center informed consent form and was given the opportunity to

 ask questions.

**Basic Background Information**

Birthplace:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital status: \_\_\_\_\_\_\_\_\_\_ Religious affiliation \_\_\_\_\_\_\_\_\_\_\_\_

Education: Highest Grade Completed \_\_\_\_\_\_ Degree:\_\_\_\_\_\_\_ Military history:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children (First name, age): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Persons living in your home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What type of work do you do (or if retired, what did you do)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Counseling History, Needs and Goals**

**Please tell us, briefly, about your reasons for seeking counseling:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you here? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is counseling mandated?[ ]  Yes [ ]  No If yes, by whom \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please tell us about past and current counseling/psychiatric experiences:**

Provider Where? When? How long? Useful?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ [ ]  Y [ ]  N

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ [ ]  Y [ ]  N

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ [ ]  Y [ ]  N

Are you currently having suicidal thoughts: [ ]  Yes [ ]  [ ]  No If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever made a suicide attempt? [ ] [ ]  Yes [ ] [ ]  No If yes, when and how:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has anyone related to you made a suicide attempt? [ ]  Yes [ ]  No If yes, please tell us about it:\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently having homicidal thoughts: [ ] [ ]  Yes [ ] [ ]  No If yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you, or anyone related to you, ever attempted a homicide? [ ]  Yes [ ]  No If yes, please tell us about it\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you worry about your safety in your current living situation? [ ]  Yes [ ]  No If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever struck or threatened people or animals or broken things in your home?

[ ]  Yes [ ]  No If yes, please tell us about it:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What are your *strengths*?**

[ ] [ ]  bright [ ] [ ]  insightful [ ] [ ]  motivated [ ]  [ ]  active [ ]  good listener

[ ] [ ]  have self-control [ ] [ ]  have friends [ ] [ ]  can calm myself [ ]  [ ]  mostly healthy [ ] stable

[ ] [ ]  can ask for help [ ]  keep my boundaries [ ]  [ ]  have moral ethics [ ]  [ ]  have employment

[ ] [ ]  can forgive [ ]  can express feelings [ ]  [ ]  have enough money to meet my needs [ ] [ ]  patient

[ ] [ ]  resourceful [ ] [ ]  sense of humor [ ]  [ ]  compassionate [ ] [ ] [ ]  can solve problems

[ ]  satisfied with employment [ ]  willing to learn new attitudes and behaviors [ ]  can accept love & care from others

[ ]  other strengths:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check any *concerns* you are having:**

[ ]  [ ]  Loss of loved one through death [ ]  Separation from loved one [ ]  [ ]  Divorce

[ ]  [ ]  Change of jobs [ ]  [ ]  Loss of employment [ ]  [ ]  Lifecycle transition

[ ]  [ ]  Marriage [ ]  Employment conflicts [ ]  [ ] [ ]  [ ]  Stress

 [ ]  Spouse/significant other conflict [ ]  [ ]  Family conflict [ ]  [ ]  Parenting issues

[ ]  [ ]  Custody issues [ ]  Pregnancy [ ] [ ]  Fertility issues

[ ]  [ ]  Behavior of adult children [ ] [ ]  Health problems [ ]  [ ]  Retirement

[ ]  [ ]  Health problems in family [ ]  [ ]  Victim of physical abuse [ ]  [ ]  Financial problems

[ ]  [ ]  Substance abuse [ ]  Gambling [ ]  [ ]  Eating disorder

[ ]  [ ]  Excessive computer use [ ]  [ ]  Weight management [ ]  [ ]  Rape

[ ]  [ ]  Pornographic interest [ ]  Violent/abusive behavior [ ]  [ ]  School problems

[ ]  [ ]  Interpersonal problems [ ]  [ ]  Housing problems [ ]

**Please check any *symptoms* that apply to you:**

[ ] [ ]  headaches [ ]  dizziness [ ]  fainting spells [ ] [ ]  heart palpitations

[ ] [ ]  stomach trouble [ ]  [ ]  anxiety [ ]  fatigue [ ]  bowel disturbances

[ ] [ ]  no appetite [ ]  anger [ ] [ ]  insomnia [ ]  nightmares

[ ] [ ]  panicky feeling [ ]  drink a lot [ ]  [ ]  feel tense [ ] [ ]  conflict with others

[ ] [ ]  tremors [ ]  [ ]  use drugs [ ]  allergies [ ]  suicidal ideas

[ ] [ ]  depressed [ ]  [ ]  unable to relax [ ]  [ ]  sexual problems [ ]  shy with people

[ ] [ ]  don't like vacations [ ]  overambitious [ ]  feel driven [ ]  can't make friends

 and week-ends [ ]  inferiority feelings [ ]  [ ]  can't keep a job [ ]  memory problems

[ ] [ ]  lonely [ ] [ ]  financial problems [ ]  excessive sweating [ ] [ ]  can't concentrate

[ ] [ ]  unable to have a good time [ ] [ ]  can't make decisions [ ]  home conditions bad

[ ] [ ]  often use aspirin or painkillers [ ]  other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check any words that you think apply to you:**

**[ ]** **[ ]**  worthless [ ]  [ ]  useless [ ] [ ]  a "nobody" [ ]  [ ]  "life is empty" [ ] [ ]  inadequate

[ ]  [ ]  stupid [ ]  [ ]  repulsive [ ]  naïve [ ]  [ ]  incompetent [ ]  "can't do anything right"

[ ]  [ ]  guilty [ ]  [ ]  evil [ ] [ ]  hostile [ ]  [ ]  full of hate [ ] [ ]  jittery

[ ]  [ ]  agitated [ ]  [ ]  morally wrong [ ]  cowardly [ ] [ ]  horrible thoughts [ ] [ ]  unassertive

[ ]  [ ]  panicky [ ]  [ ]  aggressive [ ] [ ]  ugly [ ]  deformed [ ]  [ ]  unattractive

[ ]

**Social History**

Please list your brothers and sisters and their ages \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was your childhood unusual in any way? [ ]  Yes [ ] [ ]  No If yes, how?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have you been married, how often and how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you experienced any significant traumatic events? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you experienced any significant losses?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe any significant legal history (i.e., arrest, bankruptcy) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything else that you want us to know? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

Family Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last physical examination:\_\_\_\_\_\_\_\_\_\_\_\_

Other Medical Prescribers seen and why:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check any illness you *currently* have *or* have had *in the past*:**

[ ]  Diabetes [ ]  High Blood Pressure [ ]  Lung Disease [ ]  Venereal Disease

[ ]  Asthma [ ]  Low Blood Pressure [ ]  Cancer (syphilis/gonorrhea)

[ ]  Arthritis [ ]  Heart Disease [ ]  Kidney Disease [ ]  Head Injuries

[ ]  Pneumonia [ ]  Thyroid Disease [ ]  Hepatitis [ ]  Jaundice

[ ]  Anemia [ ]  Tuberculosis [ ]  Cirrhosis [ ]  Muscular Disorder

[ ]  Ulcer [ ]  Colitis [ ]  Bone Disorder [ ]  Obesity

[ ]  Seizures [ ]  Nerve Disorder [ ]  Anorexia [ ]  AIDS/HIV

[ ]  Depression [ ]  Anxiety [ ]  Other Mental Illness

[ ]  Alcohol/Drug Problems [ ]  Other (please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please tell us about your past hospitalizations (include surgeries, psychiatric or substance abuse treatment – use back of page if necessary):**

Date Reason Hospital Physician

\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you taking any medications now?** **[ ]  Yes** **[ ]  No. If yes, please list and include over-the-counter medications you take routinely.**

|  |
| --- |
| **Result** |
| Very good | Good | Fair | Poor | AdverseReaction |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Medication/ How often? Reason**

 **Dosage**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you take supplements or herbs routinely?** **[ ]  Yes** **[ ]  No If yes, please list:**

Supplement/Herb Dosage How often? Reason for Use

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had side effects/allergic reactions from taking medication?

[ ]  Yes [ ]  No. If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please tell us how much caffeine you consume:**

Estimated daily consumption of coffee or tea \_\_\_\_\_\_\_\_\_\_\_\_\_ cups/day

Estimated daily consumption of soda or cola \_\_\_\_\_\_\_\_\_\_\_\_\_ ounces/day

**Psychiatric/Substance Use Information**

**Please tell us about your family's history of alcoholism, substance abuse and psychiatric problems.** Indicate which, if any, family members you either suspect has had difficulties in these areas and/or has received treatment for these problems.

|  |  |  |
| --- | --- | --- |
| **Relationship** | **Problem** **(specify alcoholism, substance abuse or psychiatric)** | **Problem suspected or actually treated?** |
| GrandparentsMotherFatherBrother/SisterChildrenSpouse/Sig. OtherOther (who?) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Do you have a history of IV drug use? [ ] [ ]  Yes [ ]  No

Do you drink socially? How often? \_\_\_\_\_\_\_\_\_\_\_\_\_ How much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How old were you when you took your first drink? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever felt you needed to cut down on your drinking? [ ]  Yes [ ]  No

Have people annoyed you by criticizing your drinking? [ ]  Yes [ ]  No

Have you ever felt guilty about drinking? [ ]  Yes [ ]  No

Have you ever felt you needed a drink first thing in the morning (eye-opener) to steady your

 nerves or to get rid of a hangover? [ ]  Yes [ ]  No

Have you ever attended A.A., Alanon, or N.A.? [ ]  Yes [ ]  No

Have you ever had a D.U.I? [ ]  Yes [ ]  No If yes, how many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been arrested for a drinking or drug-related offense of any kind? [ ]  Yes [ ]  No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
|  | **No Current****Use** |  | **Current** **Use** |
| **Substance** **Category** | **Common Names****(circle all that apply)** | **Never****Used** | **Did****Use****But Quit** | **Less than****once****per mo.** | **1 – 4X****per** **mo.** | **1 – 4X****per** **week** | **1 or** **More X** **Per Day** | **Age****First****Used** |
| **Tobacco/** **Nicotine** | Cigarettes Snuff CigarsChewing Tobacco E-cigarettes |  | **Date:** |  |  |  |  |  |
| **Alcohol** | Beer Wine Hard Liquor |  | **Date:** |  |  |  |  |  |
| **Cannabis or** **Synthetic Marijuana** | Marinol Pot Hashish Grass Weed Hash Oil Reefer GanjaJoint Mary Jane Spice/K2 Kush |  | **Date:** |  |  |  |  |  |
| **Stimulants** | Cocaine (Coke; Snow; Crack; Rock; Blow; Nose; Toot; White);CrystalAmphetamines; Speed; Crank Uppers; Dexedrine; Ritalin; AdderallMethamphetamine; Diet Pills |  | **Date:** |  |  |  |  |  |
| **Depressants** | Tranquilizers; Sleepers; 'LudesBenzos (Xanax; Valium; Klonopin; Ambien, etc.) Barbiturates; Downers |  | **Date:** |  |  |  |  |  |
| **Inhalants** | Glue Gasoline AerosolsAmyl Nitrate Poppers Paint ThinnersRush Nitrous Whippets |  | **Date:** |  |  |  |  |  |
| **Narcotics** | Heroin Smack Horse Morphine Methadone Darvocet Codeine Percodan Hydrocodone TramadalOxycontin Vicodin Lortab Dilaudid Fentanyl Patch Duragesic Patch |  | **Date:** |  |  |  |  |  |
| **Hallucinogens** | LSD Peyote Mescaline PCP Acid Mushrooms MDMA(Molly; “X”; Ecstasy) Bath Salts Love Drug |  | **Date:** |  |  |  |  |  |
| **Over-the-Counter****Drugs** | Cold Pills Diet Pills Cough Syrups No Doz Sleep Aids Purple DrankMini Thins Yellow Jackets |  | **Date:** |  |  |  |  |  |