This form is to save you and your practitioner's time in the interest of providing you with the best service possible. All information on this form is considered confidential. Please answer as carefully and completely as possible.

Name: _____

Date: _____

Referred By: _____ Phone #: _____

About your current problems

List the problems of greatest concern to you.

Describe the problems in your own words.

ANY PRIOR PSYCHIATRIC, PHYSOLOGICAL, OR CHEMICAL DEPENDENCY SERVICES.

Name of treatment setting; i.e., outpatient/inpatient	**Practitioners seen**	**Dates of Service**	**Were services helful?**

SUBSTANCE ABUSE HISTORY

	YES	*NO*
Have you ever felt you should cut down on your drinking/drug use?		
Have people annoyed you by criticizing your drinking/drug use?		
Have you ever felt bad or guilty about your drinking/drug use?		
Have you ever drank/used drugs in the morning to steady your nerves or relieve a hangover?		

FAMILY MEDICAL, PSYCHIATRIC AND CHEMICAL DEPENDENCY HISTORY
PLEASE NOTE WITH A b IN THE APPROPRIATE BOX IF THESE CONDITIONS ARE CURRENT OR HAVE OCCURRED IN RELATIVES

	Children	**Siblings**	**Mother**	**Father**	**Uncles/ Aunts**	**Grandparents**	**Others**
Nervous Problems (anxiety)							
Depression							
Psychiatric Treatment							
Drinking Problems							
Drug Abuse							
Other							
Medical Conditions							
Medical Treatment							

Have you had a problem/diagnosis/treatment procedure regarding any of the following? Please check (b) all that apply. Not whether they are current or past problems.

Current	Past	
		Shortness of Breath
		Coughing up blood
		Bleeding from any part of the body
		Chest pain/ palpitation
		Infection
		Stroke
		Sudden loss of Smell, Taste, Vision, Hearing, Sensation
		Convulsions/ Seizures
		Motor coordination/ paralysis
		Sexually transmitted disease
		Frequent severe headaches
		Frequent lingering cough
		Swelling of the hands & feet
		Night sweats/ fevers
		Dizziness/ fainting spells
		Pain in back or extremities
		Jaundice/ hepatitis
		Increased thirst/ urination
		Abdominal pain
		Eating disorder
		Unintentional weight loss/ gain
		Joint/ back problems
		Bleeding mole

Current	Past	
		Asthma
		Thyroid/ gland problems
		High blood pressure
		Diabetes
		Kidney disease/ stones
		Cancer (within last 5 years)
		Arthritis
		Tuberculosis/ exposure
		Heart disease
		Anemia
		Ulcers
		Epilepsy
		Skin problems
		Nutrition problems
		Smoking
		Drugs
		Alcohol
		Hormone replacement therapy
		Other:
		Surgeries/ injuries:

Adverse / Allergic Drug Reactions:

Current / Recent Medications:

Name:	Dose:	Frequency:	Start	Stop

Primary Care Provider's Name:

Name:	Dose:	Frequency:	Start	Stop

Alternative Medications/Vitamins:_____

Highest weight:_____ Current Weight_____ Height_____ Number of Pregnancies_____

Regular menstrual periods Yes/ No

Place of Birth: _____

Family Data:

Father: Living or deceased? Age if living: _____

Occupation: _____

Health status: _____

If deceased, cause of death: _____

Frequency and nature of contact: _____

Mother: Living or deceased? Age if living: _____

Occupation: _____

Health status: _____

If deceased, cause of death: _____

Frequency and nature of contact: _____

Brothers/ Sisters:

Name	**Sex**	**Age**	**Resides where?**

Did you live with anyone other than your natural parents for any significant time during your childhood years?

RELATIONSHIP HISTORY

Marital status: Single t Married t Divorced t Widowed t Partnered t

If married, remarried or partnered, for how long? _____

If divorced, separated, or widowed, for how long? _____

If previously married or in a long-term relationship, when? _____ how long? _____

Spouse/ partner's age: _____

Spouse/ partner's occupation: _____

Spouse/ partner's prior marriages: _____ When? _____ How long? _____

Children/ stepchildren:

Name	**Sex**	**Age**	**Resides where?**

LIVING ARRANGEMENTS/ HOME ENVIRONMENT

With whom do you currently live? _____

Are there any concerns about living arrangements? _____

EDUCATIONAL HISTORY

Highest level of education completed _____

Did you receive any special educational services? _____

OCCUPATIONAL HISTORY

Occupation: _____ Current position held: _____

If not currently working, date you last worked: _____

List names of employers: _____

_____

_____