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Client's name: _____ DOB:_____

Legal Guardian (if minor): _____ Form completed by: _____

Address:_____City:_____State:_____Zip:_____

Phone (home):_____(work):_____ Email: _____

Primary Insurance: _____ Policy ID#_____ Group ID# _____ Subscriber: _____

Secondary Insurance: _____ Policy ID#_____ Group ID# _____ Subscriber: _____

Person Responsible for Payment _____Soc. Sec. # _____

Signature of Responsible Person: _____

Reasons for seeking treatment: _____

Have you ever been diagnosed with any of the following? __Depression __Bipolar __Mood disorder __Anxiety __PTSD __OCD __ADHD __Eating disorder __Schizophrenia __Psychosis __Addiction

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

Aggression	Loneliness	Hyperactivity	Thoughts disorganized
Anxiety	Withdrawing	Elevated mood	Panic attack
Anger	Worthlessness	Gambling	Heart palpitations
Anti-social Behavior	Guilt	Sexual addiction	Chest Pain
Alcohol Dependence	Excessive worry	Low Libido	Trembling
Avoiding People/social settings	Irritability	Mood shifts	Numbness
Binging/Purging	Feeling on edge	Hypersexual	Dizziness
Restricting food/calorie counting	Restlessness	Impulsivity	Disorientation
Cyber addiction	Phobias/fears	Judgment errors	Sick often
Depression	Fatigue	Excessive spending	Speech problems
Tearful	Intrusive thoughts	Sleeping problems	Suicide attempts
Hopeless	Obsessions/Compulsions	Hallucinations	Racing thoughts
Helplessness	Drug dependence	Paranoia	Relationship stress
	Distractibility	Bizarre Behavior	Work Stress

Do you currently feel suicidal? **YES / NO** If Yes, explain:_____

Briefly discuss how the above symptoms impair your ability to function effectively: _____

What are your goals for therapy or treatment?

1. _____
2. _____
3. _____

COUNSELING/PRIOR TREATMENT HISTORY:

Therapist/counselor: _____ Ph #: _____

Previous Psychiatric Prescriber: _____Ph#_____

Suicide thoughts/attempts: _____

Drug/alcohol treatment:_____

Hospitalizations: _____

Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous): _____

FAMILY HISTORY:

Where you Adopted? **YES/NO** Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.):_____

___ Parents legally married ___ Parents divorced (Age)_____ ___ Parents never married ___ Mother remarried: ___ Father remarried:

Has someone in your family been diagnosed OR have had a problem with depression, anxiety, bipolar, ADHD, suicide or drugs or alcohol? **YES/NO** If Yes, describe: _____

_____

Family Medical History: _____

MEDICAL/PHYSICAL HEALTH HISTORY:

Primary Care Physician: _____Last physical exam: _____

Abnormal Lab results: _____

Are you allergic to any medications or drugs? **YES / NO** If Yes, describe: _____

Surgery History _____

Current medications and supplements (Dose, Dates started, Purpose, Side effects): _____

_____
_____
_____

Past History of Psychiatric Medications: (Include dose, dates used, purpose for use, side effects):

_____
_____
_____
_____

Review of Symptoms: (Please circle any physical symptoms or illness you have been treated for).

Abdominal Pain	Constipation	Hearing Problems	Sexual Problems
Abortion	Crohn's Disease	Hepatitis	Sleeping disorders
AIDS	Colds/Cough	Kidney Problems	Shortness of breath
Allergies	Dental Problems	Learning Disorders	Sore throat
Alcoholism	Diabetes	Measles/Mumps	Scarlet fever
Anemia	Diarrhea	Menstrual Pain	Sinusitis
Appendicitis	Dizziness	Miscarriages	Smallpox
Arthritis	Drug Abuse	Mononucleosis	Stroke
Asthma	Eating problems	Nausea	Tonsillitis
Autoimmune Disorders	Ear Infections	Neurological Disorders	Tuberculosis
Bed Wetting	Epilepsy	Nose bleeds	Thyroid problems
Bleeding Disorders	Fainting	Obesity	Vision problems
Bronchitis	Fatigue	PMS	Vomiting
Cancer	Fibromyalgia	Pneumonia	Whooping cough
Chest Pain	Frequent Urination	Rheumatic fever	Other:_____
Chicken Pox	High Blood Pressure	Sexually transmitted diseases	
Chronic Pain	Headaches		

NUTRITION:

Height:_____ **Weight:** _____ **Recent Weightt loss or gain: +/-** _____

Past/present issues with restricting, binging, purging, use of laxatives? **YES / NO**_____

Typical foods eaten

Breakfast;_____ Lunch: _____

Dinner: _____ Snacks: _____

Special diet followed: _____

SUBSTANCE USE HISTORY: Circle ALL of the following that have been used

Alcohol	Methamphetamines	Other: _____
Barbiturates	Hallucinogens	
Benzodiazepines	Caffeine	Drug of Choice:
Cocaine/Crack	Nicotine	_____
Heroine/Opiates	Spice	_____
Marijuana	Inhalants	_

For ALL chemicals circled, please describe age of first use, amount used, frequency of use and last use:

_____

_____

Reason(s) for use: ___ Addicted ___Build confidence ___Escape ___Self-medication ___ Socialization ___ Taste ___ Other (specify):

_____

Describe any changes in your use patterns: _____

Describe how your use has affected your family, friends or work: _____

Who or what has helped you in stopping or limiting your use? _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? **YES / NO** If Yes, describe: _____

SOCIAL HISTORY:

Marital Status (more than one answer may apply): __Single __Married ___Divorce d __Life partner ___Separated __Widowed
Satisfaction of current relationship___ Good___ Fair___ Poor

Sexual orientation: _____Sexual dysfunctions? **YES / NO** If Yes, describe:_____

Children (Names and Ages): _____

Significant others/Support Systems: (e.g., siblings, grandparents, step relatives, half relatives. Please specify relationship.):

_____

_____

Check how you generally get along with other people: (check all that apply)

___ Affectionate ___ Aggressive ___ Avoidant ___ Fight/argue often ___ Follower ___Friendly ___ Leader ___ Outgoing ___ Shy/withdrawn
___ Submissive ___ Other (specify):_____

Hobbies: _____

DEVELOPMENTAL HISTORY:

Any exposure to drug/alcohol in Utero? YES/NO _____

Complications with pregnancy or after Birth? YES/NO: _____

Did you meet developmental milestones? YES/NO: _____

Has there been history of child abuse? **YES / NO** If Yes, which type(s)? ___ Sexual ___Physical ___ Verbal ___Emotional/Mental ____Neglect
Other: _____

EDUCATION:

Any difficulties with school or learning: _____

Highest level of education: _____

Vocational or specialty training: _____ _____

EMPLOYMENT:

Currently: ___FT ___PT ___Temp ___Laid-off ___Disabled ___Retired ___Social Security ___ Student ___LOA ____Other (describe):_____

Work History: _____

Reasons for terminations:_____

How often miss work? _____

CULTURAL/ETHNIC:

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? **YES / NO** If Yes, describe: _____

Do you have cultural beliefs/practices that help or interfere with mental health? _____

SPIRITUAL/RELIGIOUS:

How important to you are spiritual matters? ___ None ___Little ___Moderate___ Very Much Religious Affiliation: _____

Spiritual practices or concerns: _____

LEGAL:

Are you involved in any active legal cases (traffic, civil, criminal)? **YES / NO** (Please describe and indicate case/charges and the court dates: _____

History of Legal Issues: _____

Are you presently on probation or parole? **YES NO: D**escribe: _____ Parole Officer: _____

MILITARY:

Military experience? **YES / NO**

Combat experience? **YES / NO** When/Where:_____ Branch: _____ Dates enlisted: _____Discharge date: _____

Type of discharge: _____ Rank at discharge: _____