**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:** \_\_\_\_\_\_\_\_\_\_\_\_\_

I received the Counseling & Wellness Center informed consent form and was given the opportunity to ask questions.

**This form will be treated as part of your medical record.**

**Please ask about any items you do not understand.**

(for more extensive answers, complete on back)

Self Report  Assisted Report If so, by who:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_ Sex\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_\_\_ Height\_\_\_\_\_\_\_\_\_\_\_\_

Family Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Therapist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person who referred you here\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Power or attorney (medical)  No  Yes Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History**

**(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  Jaundice Kidney Disease

Thyroid Disease  Pneumonia  Hepatitis  Head Injuries

Anemia  Tuberculosis  Cirrhosis  Injuries

Ulcer  Colitis  Bone Disorder  Muscular Disorder

Nerve Disorder  Seizures  Anorexia  Obesity

Other (please describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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**Past Hospitalization** *(Particularly Psychiatric or Substance Abuse Treatment)*

**Date Reason Hospital Doctor**

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

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

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

**History of Mental Health & Substance Dependence Treatment**

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

Provider Where? When? How long? Useful?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_  Y  N

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_  Y  N

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_  Y  N

**Reason for Seeking Medical/Counseling Services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medications**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Result** | | | | |
| Very good | Good | Fair | Poor | Adverse  Reaction |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
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|  |  |  |  |  |

Medication Dosage Reason Current Past Psychiatric

\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_  Y  N

\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_  Y  N

\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_  Y  N

\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_  Y  N

\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_  Y  N

\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_  Y  N

\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_  Y  N

\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_  Y  N

\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_  Y  N

\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_  Y  N

**Over-the counter medications** or **herbs** used for medical or psychiatric illness

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

**DRUG SENSITIVITIES & TYPES OF REACTION\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**ALLERGIES** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 ever been in the Military?  Yes  No If yes, dates of service?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Honorable Discharge?  Yes  No  N/A If no, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you or any family member ever struck or threatened people or animals or broken things in your home?  Yes  No If yes, please tell us about it:

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

**Family History of**

**Alcoholism/Substance Abuse & Psychiatric Problems:**

*(Indicate which, if any, family members you either suspect has had difficulties in these*

*areas or has received treatment for these problems)*

|  |  |  |
| --- | --- | --- |
| **Relationship** | **Problem** **(specify alcoholism, substance abuse or psychiatric)** | **Problem suspected or actually treated?** |
| Grandparents  Mother  Father  Brother/Sister  Children  Spouse/Sig. Other  Other (who?) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Have you, or anyone related to you, ever attempted suicide?  Yes  No

If yes, please describe ­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Have you, or anyone related to you, ever attempted a homicide?  Yes  No

If yes, please describe ­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | | **No Current**  **Use** | | **Current Use** | | | |
| **Substance**  **Category** | **Common Names**  **(circle all that apply)** | Never  Used | Used  But Quit | Less  Than  1X  per mo. | 1 - 4  Times  per  mo. | 1 - 4  Times  per  wk. | 1 or More  Times  Per Day |
| **Tobacco/**  **Nicotine** | Cigarettes Snuff Cigars  Chewing Tobacco E-cigarettes | A | B  Date: | C | D | E | F |
| **Alcohol** | Beer Wine Hard Liquor | A | B  Date: | C | D | E | F |
| **Cannabis or**  **Synthetic Marijuana** | Marinol Pot Hashish Grass  Weed Hash Oil Reefer Ganja  Joint Mary Jane Spice/K2 Kush | A | B  Date: | C | D | E | F |
| **Stimulants** | Cocaine (Coke; Snow; Crack; Rock; Blow; Nose; Toot; White);Crystal  Amphetamines; Speed; Crank Uppers; Dexedrine; Ritalin; Adderall  Methamphetamine; Diet Pills | A | B  Date: | C | D | E | F |
| **Depressants** | Tranquilizers; Sleepers; 'Ludes  Benzos (Xanax; Valium; Klonopin; Ambien, etc.) Barbiturates; Downers | A | B  Date: | C | D | E | F |
| **Inhalants** | Glue Gasoline Aerosols  Amyl Nitrate Poppers Paint Thinners  Rush Nitrous Whippets | A | B  Date: | C | D | E | F |
| **Narcotics** | Heroin Smack Horse Morphine Methadone Darvocet Codeine Percodan Hydrocodone Tramadal  Oxycontin Vicodin Lortab Dilaudid Fentanyl Patch Duragesic Patch | A | B  Date: | C | D | E | F |
| **Hallucinogens** | LSD Peyote Mescaline PCP Acid Mushrooms MDMA(Molly; “X”; Ecstasy) Bath Salts Love Drug | A | B  Date: | C | D | E | F |
| **Over-the-Counter**  **Drugs** | Cold Pills Diet Pills Cough Syrups No Doz Sleep Aids Purple Drank  Mini Thins Yellow Jackets | A | B  Date: | C | D | E | F |

**Medical History Questionnaire – Please Check All That Apply**

|  |  |  |
| --- | --- | --- |
| ***REVIEW OF SYSTEMS:***  ***HEAD & NECK***  frequent headache  neck pain  neck lumps/swelling  trouble swallowing  ***EYES***  blurry vision  eyesight worsening  sees double  ***EARS***  hearing problems  earaches  discharge  buzzing in ears  ringing in ears  motion sickness  ***MOUTH***  dental problems  grinding of teeth  ***NOSE & THROAT***  smells odor  congested nose  running nose  nose bleeds  sore throat  enlarged tonsils  hoarse voice  ***RESPIRATORY***  sometimes breathes too fast  short of breath  coughing spells  coughs up blood  chest colds  other problems  ***MUSCULOSKELETAL***  aching muscles & joints  back pain  leg cramps  swollen joints  ***SKIN***  dry skin  skin rash  itching or burning skin  bleeds or bruises easily  changes in color | ***NEUROLOGICAL***  faintness  numbness  tingling  convulsions  change in handwriting  clumsiness  loss of strength  paralysis  stroke  memory problems  trouble thinking  head injury  knocked unconscious  ***CARDIOVASCULAR***  high blood pressure  racing heart  chest pains  need more pillows to breath  at night  swollen feet/ankles  heart murmur  ***DIGESTIVE***  heartburn  belching  indigestion  stomach pain  nausea  vomiting blood  constipation  loose stools  black stools  pain in rectum  rectal bleeding  ***MALE GENITALIA***  weak urine stream  prostate trouble  impotence  burning/discharge  lumps in testicles  painful testicles  decreased interest in sex  ***URINARY***  night frequency  day frequency  wet pants or bed  burning urination  blood in urine  difficulty starting stream | ***FEMALE GENITALIA***  menstrual trouble  breakthrough bleeding  irregular cycles  heavy bleeding  bleeding after intercourse  pain during intercourse  premenstrual tension  hot flashes  breast lumps  vaginal discharge  PAP smear (date)\_\_\_\_\_\_\_\_\_\_  last period started­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_  method of contraception\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***PREGNANCY***  pregnancies #\_\_\_\_\_  miscarriages #\_\_\_\_\_  stillbirths #\_\_\_\_\_  premature births #\_\_\_\_\_  deliveries #\_\_\_\_\_  abortions #\_\_\_\_\_  ***GENERAL***  weight gain \_\_\_\_\_lbs.  weight loss \_\_\_\_\_lbs.  feeling too hot  feeling too cold  loss of appetite  always hungry  always thirsty  armpits or groin swelling  fatigue  bites nails  trouble falling asleep  trouble staying asleep  sleeps too much  wakes earlier than usual  morning headache  loud snoring  excessive seating  night sweats  excessive daytime sleepiness |

**What are your *strengths*?**

bright  insightful  motivated  active  good listener

have self-control  have friends  can calm myself  healthy stable

can ask for help  keep my boundaries   have moral ethics  employed

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

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Signature/Date** (Signature indicates the above has been read. I agree that any terms I do not understand should be discussed with the provider.)