**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)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

**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 | AdverseReaction |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

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?** |
| GrandparentsMotherFatherBrother/SisterChildrenSpouse/Sig. OtherOther (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)** | NeverUsed | UsedBut Quit | LessThan1X per mo. | 1 - 4Timesper mo. | 1 - 4Timesper wk. | 1 or More TimesPer Day |
| **Tobacco/** **Nicotine** | Cigarettes Snuff CigarsChewing Tobacco E-cigarettes | A | BDate:  | C | D | E | F |
| **Alcohol** | Beer Wine Hard Liquor | A | BDate:  | C | D | E | F |
| **Cannabis or** **Synthetic Marijuana** | Marinol Pot Hashish Grass Weed Hash Oil Reefer GanjaJoint Mary Jane Spice/K2 Kush | A | BDate:  | C | D | E | F |
| **Stimulants** | Cocaine (Coke; Snow; Crack; Rock; Blow; Nose; Toot; White);CrystalAmphetamines; Speed; Crank Uppers; Dexedrine; Ritalin; AdderallMethamphetamine; Diet Pills | A | BDate:  | C | D | E | F |
| **Depressants** | Tranquilizers; Sleepers; 'LudesBenzos (Xanax; Valium; Klonopin; Ambien, etc.) Barbiturates; Downers | A | BDate:  | C | D | E | F |
| **Inhalants** | Glue Gasoline AerosolsAmyl Nitrate Poppers Paint ThinnersRush Nitrous Whippets | A | BDate:  | C | D | E | F |
| **Narcotics** | Heroin Smack Horse Morphine Methadone Darvocet Codeine Percodan Hydrocodone TramadalOxycontin Vicodin Lortab Dilaudid Fentanyl Patch Duragesic Patch | A | BDate:  | C | D | E | F |
| **Hallucinogens** | LSD Peyote Mescaline PCP Acid Mushrooms MDMA(Molly; “X”; Ecstasy) Bath Salts Love Drug | A | BDate:  | C | D | E | F |
| **Over-the-Counter****Drugs** | Cold Pills Diet Pills Cough Syrups No Doz Sleep Aids Purple DrankMini Thins Yellow Jackets | A | BDate:  | 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.)