Into the Wild
Program Application

Personal Information

Name: ____________________ Date: ____________________
Address: ____________________
Phone: ____________________ Email: ____________________
DOB: ____________________ Sex: ____________________
Primary Physician: ____________________ Phone: ____________________
Current Therapist: ____________________ Phone: ____________________

Complaint

What is your major complaint? ____________________
Start Date: ____________________ Have you previously suffered from this complaint? ____________________
Previous therapist(s) seen for complaint: ____________________
Previous treatment for complaint: ____________________
Aggravating Factors: ____________________
Relieving Factors: ____________________

Current Symptoms (Check All That Apply)

☐ Anxiety	☐ Appetite Issues	☐ Avoidance	☐ Crying Spells
☐ Depression	☐ Excessive Energy	☐ Fatigue	☐ Guilt
☐ Hallucinations	☐ Impulsivity	☐ Irritability	☐ Libido Changes
☐ Loss of Interest	☐ Panic Attacks	☐ Racing Thoughts	☐ Risky Activity
☐ Sleep Changes	☐ Suspiciousness	☐	☐

Medical History

Exercise Frequency: ____________________ Exercise Type(s): ____________________
Allergies: ____________________
What medications are you currently using? ____________________
Previous diagnoses/mental health treatment: ____________________
Previously treated by: ____________________
Previous medications: ____________________
Dates treated: ____________________
Previous medical conditions: ____________________
Previous surgeries: ____________________

Family History

Were you adopted? ____________________ If yes, at what age? ____________________
How is your relationship with your mother? ____________________
How is your relationship with your father? ____________________
Siblings and their ages: ____________________
Are your parents married? ____________________
Did your parents divorce? ____________________ If yes, how old were you? ____________________
Did your parents remarry? ____________________ If yes, how old were you? ____________________
Who raised you? ____________________ Where did you grown up? ____________________
Family member medical conditions: ____________________
Family member mental conditions: ____________________
Treated with medication? ____________________
Medications: ____________________

Early Development

Where did you grow up? ____________________
How often did you move and where? ____________________
How old were you when you left home? ____________________
Have any immediate family members died? __________ Who? __________
Have any committed suicide? __________ Who? __________
Describe any neglect you suffered, and by whom: ____________________
Trauma suffered and by whom: ____________________
Abuse suffered and by whom: ____________________
Highest education level completed: ____________________
Date completed and location: ____________________
Have you ever served in the military? __________ If yes, where? __________
Dates of service: __________ Highest rank achieved: __________

Present Situation

Work: ☐ Full-Time ☐ Part-Time ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired
Are you married? __________ If yes, date of marriage: __________
Are you divorced? __________ If yes, date of divorce: __________
Prior marriages? __________ If yes, how many? __________
What is your sexual orientation? __________ Are you sexually active? __________
How is your relationship with your partner? ____________________
Do you have children? __________ Dates of Birth: __________
How is your relationship with your child(ren)? ____________________
List anyone else who lives with you: ____________________
Are you a member of a religion/spiritual group? ____________________
What is your level of involvement? ____________________
Have you ever been arrested? __________ When and why? __________

Have You Ever Tried the Following (Check All That Apply)

☐ Alcohol	☐ Tobacco	☐ Marijuana	☐ Hallucinogens (LSD)
☐ Heroin	☐ Methamphetamines	☐ Cocaine	☐ Stimulants (Pills)
☐ Ecstasy	☐ Methadone	☐ Tranquilizers	☐ Pain Killers

If yes to any, list frequency/dates of use: ____________________

Have you ever been treated for drug/alcohol abuse? __________ If yes, when? __________
For which substances? ____________________
Do you smoke cigarettes? __________ If yes, how many per day? __________
Do you drink caffeinated beverages? __________ If yes, how many per day? __________
Have you ever abused prescription drugs? If yes, which ones?

Anything Else You Want Your Team to Know

____

Signature

Date