

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)

- | | | | |
|----------------------------------|---|--|--|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Tobacco | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Hallucinogens (LSD) |
| <input type="checkbox"/> Heroin | <input type="checkbox"/> Methamphetamines | <input type="checkbox"/> Cocaine | <input type="checkbox"/> Stimulants (Pills) |
| <input type="checkbox"/> Ecstasy | <input type="checkbox"/> Methadone | <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> 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 the Doctor to Know

Signature _____

Date _____