***Please take a moment to fill out this questionnaire. This information is used to aid in proper diagnosis and treatment. Please print and bring with you to your first appointment.***

NAME:

ADDRESS:

PHONE:

DOB:

SS#

INSURANCE:

 ID#

PCP:

PLEASE EXPLAIN YOUR CURRENT SITUATION:

WHAT ARE YOU CURRENTLY DOING TO COPE WITH THE SITUATION:

PAST TREATMENT HISTORY:

MARRIED: Y/N SPOUSE’S NAME AGE:

 HOW LONG:

CHILDREN: Y/N

 NAME: AGE:

 NAME: AGE:

 NAME: AGE:

PREVIOUS MARRIAGE: Y/N

MOTHER’S NAME:

FATHER’S NAME:

JOB HISTORY:

 MOST RECENT EMPLOYER:

 PRIOR EMPLOYER:

DO YOU CUREBTLY DRINK ALCOHOL? Y/N HOW MUCH PER WEEK?

DO YOU CURRENTLY USE ANY ILLEGAL DRIGS? Y/N

ARE YOU CURRENTLY TAKING MEDICAL MARIJUANA Y/N

ARE YOU CURRENTLY INVOLVED IN THE LEGAL SYSTEM? Y/N

MEDICATIONS:

PLEASE LIST YOUR SRENGHTS:

PLEASE LIST ANY OTHER INFORMATION THAT MAY BE HELPFUL IN YOUR TREATMENT: