DATE:_____

| | You | Your Partner |
|---|---|---|
| Name | | |
| Work Phone | | |
| Cell Phone | | |
| Home Phone | | |
| Birthdate / Age | | |
| Address | | |
| City & Zip | | |
| Employer | | |
| Name of Insured | | |
| Insurance Company | | |
| Insurance Plan | | |
| Insurance ID # | | |

Marital Status_____

Who are you currently living with? Names, Ages, Relationship

_____

_____

_____

Children not living with you? Give names, ages, & relationship

_____

_____

_____

How did you hear about me? _____

Referred by? _____

Describe your main concern _____

_____

**Family History**

Birthplace _____

City you spent most of your youth in _____

Parents: Married __ Separated __ Divorced ___ Deceased ___ What age were you? _____

Was alcohol or other substance abuse a problem in your family? _____

In which family members? _____ Outcome? _____

Physical, sexual, emotional abuse in your family? _____

Methods of discipline in your family? _____

Siblings: (please give name, sex, number of years older or younger than you, and indicate same or different father or mother) _____

_____

Patient Name: _____

_____

Your highest level of education obtained _____
Your Occupation _____

**Partner Information**
Birthplace _____
City you spent most of your youth in _____
Parents: Married __ Separated __ Divorced ___ Deceased ___ What age were you? _____
Was alcohol or other substance abuse a problem in your family? _____
In which family members? _____ Outcome? _____
Physical, sexual, emotional abuse in your family? _____
Methods of discipline in your family? _____
Siblings: (please give name, sex, number of years older or younger than you, and indicate same or different father or mother) _____
_____
_____

Your highest level of education obtained _____
Your Occupation _____

**Lifestyle habits**

| | Amount current using | Most ever used | When/how long ago? |
|---|---|---|---|
| Coffee (cups/day) | | | |
| Caffeinated soft drinks | | | |
| Cigarettes (packs/day) | | | |
| Cigars/pipes (per day) | | | |

| | Type(s) | Frequency |
|---|---|---|
| Current Exercise | | |
| | | |
| | | |

Current Hobbies _____
_____
_____

Hours per week spent at work _____

Patient Name: _____

**Personal Medical History**

Do you have any allergies to food/medications? □ Yes □No If Yes, please describe:

_____

Please list any prescription medication you currently use:

| Drug Name | Dosage | Frequency | Prescribing Doctor | Purpose |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Please list any over-the-counter medications you currently use such as vitamins, sleeping/diet pills, aspirin/pain relievers, etc. Include name, dosage, frequency):

| Drug Name | Dosage | Frequency | Purpose |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Please list hospitalizations from past medical/surgical illnesses (include name of hospital, dates of confinement, illness/procedure)

_____

When was your last physical examination done? (Include date, doctor's name)

_____

Were there any significant findings? _____

When was your last blood test? _____

When was your last EKG? _____

Are you currently being treated for any medical conditions? □ Yes □No If Yes, please list:

_____

Do you experience any of the following? (check or circle all that apply)

- Double or poor vision
- Difficulty hearing
- Fainting
- Blackouts
- Convulsions
- Paralysis
- Dizziness
- Headaches
- Thyroid problem
- Cough or wheezing
- Chest Pain
- Shortness of breath
- Palpitation or heart fluttering
- Swelling of hands or feet
- Weight gain or loss
  #pounds: _____
  Time Period:_____
- Unusual excessive thirst / dry mouth
- Indigestion, gas, heartburn
- Stomach pain
- Diarrhea or constipation
- Vomiting / vomiting blood
- Blood in Stool
- Change in appetite or eating habits
- Trouble sleeping
- Sexual problems
- Problems with memory, thinking, concentration or attention
- Weakness or tiredness
- Joint Pain
- Lumps anywhere on body – please specify location:
  - _____

Patient Name: _____

Have you ever used drugs or alcohol? □ Yes □No If Yes, please list:

| Substance | Amount | Frequency | Last Taken |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Do you have a history of blackouts, seizures or withdrawal symptoms? □ Yes □No If Yes, please list:

_____

Have you ever received mental health or substance abuse treatment before? □ Yes □No If Yes, please list:

| Type of Treatment | Provider Name | First Seen | Last Seen | If applicable, please list type of medication and dosage taken for condition |
|---|---|---|---|---|
| | | | | |
| | | | | |

Are there any compulsive/repetitive behaviors or thoughts that are of concern to you and/or the people close to you? (i.e. gambling, spending, sexual behavior, use of food, exercise, television watching, hoarding, checking, counting, washing, illness related, thoughts of harming someone, use or fear of use of obscene language, etc.)

□ Yes □No If Yes, please list:

_____