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PERSONAL INFORMATION

Print Name _____ Date of birth _____

Street Address _____City _____ State _____ Zip _____

Email address _____

Phone: Home _____ Work _____ Cell _____

Occupation _____ Employer _____

Referred by _____ Marital status _____

Names & ages of children _____

Names & ages of parents (or year of death) _____

Names & ages of siblings _____

Religious background _____

Family history of alcoholism, mental illness, violence, scuicide _____

_____

Past/present drug or alcohol use _____

_____

Medications currently taking _____

Are you interested in lowering your medications or becoming drug free? _____

Vitamin supplements currently taking _____

List known or suspected allergies _____

Continue on next page

List major illnesses, injuries, surgeries, hospitalizations _____

_____

_____

List major difficulties or traumas in your history _____

_____

_____

_____

List the major problematic relationships in your history and current life _____

_____

_____

What would you like to work on?_____

_____

_____

_____

_____

List previous therapy or health care regarding the issues you want to work on: _____

_____

_____

What else would you like me to know?_____

_____

_____

_____

_____