

Education:

Please indicate your current standing:

- did not graduate High School high School Diploma GED associates/bachelors degree
 doctorate

Did you have any behavioral or learning issues? Yes / No

If yes, please explain: _____

Residence Situation:

- lives with parents lives with significant other lives with spouse lives alone
 other _____

Family Composition

Religion (Optional) Catholic Protestant Jewish Hindu Other: _____

How important are your Religious/Spiritual Beliefs:

- very Important somewhat important not important

Would you like to talk to your therapist about your religious/spiritual beliefs? Yes / No

Race (Optional) Caucasian African-American Native American
 Hispanic Asian-American Other: _____

Would you like to talk to your therapist about any racial/cultural issues?

Yes / No

Behavioral Health Treatment History:

Have you ever seen a behavioral health care provider before? Yes / No

If yes inpatient or outpatient? _____

If yes for Inpatient, Name of Facility: _____

Address: _____

Length of Stay: _____ Number of admissions: _____

If yes for Outpatient, Name of Facility: _____

Address: _____

Name of Therapist: _____

What type of therapist were they? Psychiatrist Psychologist Social Worker

Other: _____

When did you see the therapist and for what reason:

Medication History:

What medications do you know you should not take? _____

What medications do you know you should not discontinue to use? _____

What herbal remedy are you currently taking? _____

Client Name: _____

Please list all medications you are **currently** on or have taken in the **last year** (prescription and over-the-counter):

Who has been prescribing the medications listed above?

Name: _____

Address: _____

Telephone No.: _____

Current General Health Status:

Please describe your current general health:

() Excellent () Very Good () Good () Fair () Poor () Very Poor

Are you feeling any physical pain at this time? Yes / No

If yes please explain: _____

Nutritional Screening:

Have you **gained weight** or **lost weight** in the last 30-60 days? Yes / No

If yes, how much and why? _____

Do you have any diet or nutritional concerns? Yes / No

If yes, please explain: _____

Do you have any food or medication allergies? Yes / No

If yes, please list:

Substance Use:

Do you use Nicotine? Yes / No

If yes,

() Cigarettes/Cigars/Pipe () Chewing tobacco

Amount per day: _____ How long have you used? _____

Any related health problems? _____

Do you use Alcohol? Yes / No

If yes,

How often do you use? _____ How long have you used? _____

How much do you usually drink? _____

Any related health issues? _____

If any Recovery, Longest length of Sobriety: _____

Do you use any Illegal Drugs? Yes / No

If yes, what drug (s) do you use? _____

How often do you use? _____ How much do you use? _____

When was the last time you used? _____

Medical:

Do you feel like you need a physical exam? Yes / No

When was the last time you had a physical exam? _____

Have you suffered from any recent or childhood illnesses/disorders, operations, and/or hospitalizations (please include dates and ages)

If yes, please explain:

Head Injuries: () without loss of consciousness

() with loss of consciousness

Please

explain: _____

Convulsions: () without fever () with fever

Please

explain: _____

Abuse:

Have you ever experienced any:

() Physical Abuse

() Sexual Abuse

() Emotional Abuse

() Abandonment/Neglect

If yes, by whom: _____

Length/Duration of abuse: _____

Was it reported to the authorities: Yes / No

Please

explain: _____

Family Social History:

Name of your mother: _____ Age of mother: _____

Level of Education: _____

Name of your father: _____ Age of father: _____

Level of Education: _____

Biological parents are: () Married () Separated () Divorced () Other: _____

How would you describe your relationships with your family/siblings?:

() Excellent () Good () Fair () Poor

Please explain: _____

Family History:

Please indicate **any family history** of the following:

() Substance Abuse: If yes, indicate who: _____

() Mental Illness: If yes, indicate who: _____

() Suicide: If yes, indicate who: _____

() Autism: If yes, indicate who: _____

() Developmental Disability, if yes who: _____

() ADHD: if yes, who: _____

Social History:

Please indicate if you have any concerns regarding:

- Peer Relationships
- Marital/Significant other
- Social Support Networks
- Hobbies/Interest
- Relationships with your children
- Custody issues
- Sexual Issues

If any concerns please explain:

What do you think are your main strengths and abilities?

Legal History:

Are currently facing any pending charges or convictions? Yes / No

If yes, what for? _____

Have you ever been arrested or spent time in prison? Yes / No

Please explain? _____

Do you currently have a probation officer? Yes / No

Name of probation officer: _____ Phone Number: _____

Military History:

Were you ever in the following organizations?

- Army Air force Coast Guard Marines Navy None

Duty Status: _____ Discharge Type: _____ Rank: _____

STOP! Very Important

*** Please sign this document while you are meeting with your therapist.**

I have reviewed and addressed all issues cited on this form with the client and/or guardian.

Signature of Therapist

Date

My therapist has reviewed and addressed all my concerns cited on this form with me.

Signature of Client/Guardian

Date