Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Male [ ] Female Birthdate \_\_\_\_\_\_\_\_\_\_ Marital Status \_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_ Race \_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**YOUR CURRENT CLINICAL PROBLEMS**

|  |  |
| --- | --- |
| List problems for which evaluation is sought: | Length of time |
|  |  |
|  |  |
|  |  |

Impairment associated with current problems:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Not at all | A little bit | Moderately | Quite a bit | Extremely |
| 1. Work/School |  |  |  |  |  |
| 2. Social life |  |  |  |  |  |
| 3. Daily Activity |  |  |  |  |  |

What specific event(s) cause you to seek help at this time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all clinicians that have evaluated or treated you: [ ]  None

|  |  |  |  |
| --- | --- | --- | --- |
| Clinician | Reason | Type of Treatment | Year and Length |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |

List prescribed and non-prescribed medications you are **presently** taking:

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Reason | Dosage | Length of treatment |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

List **past** psychiatric medications taken for mental health:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication | Reason | Dosage | Start/End of treatment | Why med discontinued |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Have you ever been hospitalized for a psychiatric reason? [ ]  Yes [ ]  No

If yes, please indicate what hospital, dates, and reason:

|  |
| --- |
|  |
|  |
|  |
|  |

**YOUR PRESENT LIFE**

Partner’s/Spouse’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Years together \_\_\_\_\_\_\_\_\_\_

Age \_\_\_\_\_\_\_\_\_\_\_\_\_ Education \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Quality of relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physical or emotional problems \_\_\_\_\_\_\_\_\_\_\_\_

List all persons living in the household with you.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Age | Relationship | Education | Occupation |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| 4. |  |  |  |  |
| 5. |  |  |  |  |

Please check all events that may have occurred with in the past 12 months.

[ ]  Significant marital conflicts [ ]  Marriage

[ ]  Separation [ ]  Pregnancy

[ ]  Divorce [ ]  Birth of child

[ ]  Spouse with emotional difficulties [ ]  Gain of new family member

[ ]  Death of spouse [ ]  Child leaving home

[ ]  Death of a close family member [ ]  Significant conflicts at work

[ ]  Death of a close friend [ ]  Losing job

[ ]  Personal injury/illness [ ]  Change in job

[ ]  Change in financial status [ ]  Legal problems

[ ]  Change in residence [ ]  Other stress

Leisure and recreational activities \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Religious affiliation and practice \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any legal problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**YOUR FAMILY HISTORY**

Parents and siblings

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Age | Education | Occupation | Relationship |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| 4 |  |  |  |  |
| 5. |  |  |  |  |
| 6. |  |  |  |  |

Has any biological family member been diagnosed with a mental health diagnosis?

[ ]  Yes [ ] No

If yes, please indicate relation to family member and what mental health disorder was diagnosed.

|  |  |
| --- | --- |
| Relative | Mental health diagnosis |
|  |  |
|  |  |
|  |  |
|  |  |

**YOUR LIFE STORY**

Were there any problems with your mother’s pregnancy or delivery of you? \_\_\_\_\_\_\_\_

If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you born full term? [ ]  Yes [ ]  No Mother’s age when you were born \_\_\_\_\_\_\_

Did you experience any separation from your parents as a child? [ ]  No [ ]  Yes

If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever experienced verbal / physical abuse? [ ]  Yes [ ]  No

If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever experienced sexual abuse? [ ]  Yes [ ] No

If yes explain

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What were you like during adolescence?

[ ]  Confident [ ]  Shy [ ]  Overly active [ ]  Happy [ ]  Sociable

[ ]  Aggressive [ ]  Forgetful [ ]  Defiant [ ]  Irritable [ ]  Peaceful

[ ]  Explosive [ ]  Responsible [ ]  Rebellious [ ]  Depressed [ ]  Moody

Have you been married more than once? [ ]  Yes [ ] No

If yes explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all children residing away from home or deceased:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Age | Education | Occupation | Relationship |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| 4. |  |  |  |  |

**YOUR PHYSICAL AND HEALTH HABITS**

Your physician or family doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to medication or anything? [ ]  Yes [ ]  No

If yes explain medication/substance and reaction \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all physical problems presently under treatment or observation:

|  |  |
| --- | --- |
| Condition | Length of time |
| 1. |  |
| 2. |  |
| 3. |  |

Do you have any difficulty with drugs or alcohol? [ ]  Yes [ ]  No

Any DUI? [ ]  Yes [ ]  No

If yes to any of the above, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much alcohol do you drink on average per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much caffeine do you consume on average per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many cigarettes do you smoke per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many years? \_\_\_\_\_\_\_\_

**Only for females:**

Are you on birth control? [ ]  Yes [ ]  No

Are menstrual periods regular [ ]  Yes [ ]  No

Explain if no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List of pregnancies and age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any problems with pregnancies or deliveries? [ ]  Yes [ ]  No

If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**YOUR EDUCATION AND JOB**

Current Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Length \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Educational Degree \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year completed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your school performance:

|  |  |  |
| --- | --- | --- |
| Grade Level | Academics | Conduct |
| 1. Elementary |  |  |
| 2. Middle School |  |  |
| 3. High School |  |  |
| 4. College |  |  |

Did you pass each grade year? [ ]  Yes [ ]  No

If no, explain

|  |
| --- |
|  |
|  |

Were you ever in the military? [ ]  Yes [ ]  No

Have you ever been suspended from work? [ ]  Yes [ ]  No

If there is anything else you would like us to know, please use the space below.

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |
|  |