Name:___________________________ **DOB:**_____________**Date:**___________

Symptoms(*Check all that apply):*

- ❑ depression
- ❑ anxiety / panic
- ❑ bi-polar
- ❑ relationships
- ❑ other/comments:
- ❑ post-traumatic stress
- ❑ communication
- ❑ stress reduction
- ❑ anger management
- ❑ self-esteem

Address:____

Phone: work_________________ home______________ pager/cell______________

Sex: ___M____F___ SS#______________________ email __________________

Marital Status __S M SEP D W____ Occupation:_________________________

Employer:_________________________ Referral Source:___________________

Education Completed:_______________________ Degrees:_________________

Is it OK to call you at home?____________________ work__________________

Religious or Spiritual Beliefs: ____

Problem/Complaint

Nature of chief
complaint(s):____

____

When did the problem begin?:____

How often does it occur?:____

Current Treatment (*write none if none applies)*:

Primary care doctor/clinic:_____________________________ ph#:_____________

Psychiatrist:____ ph#:_____________

Other specialists(*specify condition & phone numbers):*______________________

____

Alternative providers (chiropractor, acupuncture…):________________________

Therapist:____

Support groups (AA, Al-anon, divorce support…): ___________________________

Current illnesses(*circle which apply)*:

- ❑ Respiratory (*bronchitis, asthma, emphysema, pneumonia, other*:
  ____)

- ❑ Cardiovascular (angina, past heart attack, high cholesterol, high blood pressure, other:____)
- ❑ Endocrine (*diabetes ,hyper/hypo thyroid, other*: ____)
- ❑ Neurologic (*past seizures, epilepsy, multiple sclerosis migraine, headaches, other:* ____)
- ❑ Muscular/skeletal (*broken bones, fibromyalgia, tension headache arthritis, other:* ____)
- ❑ Reproductive/sexual/urinary (*infertility, polycystic ovaries, impotence, lack of desire, infection, blood in urine, other :*______________________)
- ❑ Immune system (*allergies, dermatitis, eczema, HIV, cancer, other:* ____)
- ❑ Behavioral/mental health (*depression, anxiety, alcohol abuse/ dependency, drug abuse/dependency, ADD, psychosis, PTSD, other* ____)
- ❑ Other: ____

Past Illnesses/surgery:

Surgeries(*include dates):*____

Hospitalizations(*include dates & location):*______________________________

____

Illnesses(*refer to list above)*:____

Past Mental Health Treatment (*include approximate dates seen)*:

Therapists:_________________________________ Ph#:______________

____

Psychiatrists:______________________________ Ph#:______________

____

Mental health hospitalizations(*include inpatient, partial hospitalizations and intensive outpatient programs)*:_______________________________

____

Support groups/programs:____

Comments: ____

Current Medications (*specify target symptom)*:___________________________

____

____

Medication/food allergies:____

Current supplements/vitamins:____

Caffeine intake:____________**Nicotine use:**_____________________________

Current alcohol use:___________________ **Illicit drug use:**________________

Past medications or supplements taken for mood, anxiety, sleep or psychosis(*list chronologically)*:

Medication name	Taken for:	Benefit	Side effects	Dates taken

(additional form available if needed for medication/supplement history)

Leisure Activities____

Type and frequency of Exercise____

How would you describe your diet in terms of nutrition?: excellent good fair poor
Describe____

Do you have an eating disorder?___ if Yes, please specify: binge purge restrict

Are you having or have you had thoughts/plans to commit suicide or homicide?
If Yes:____

Have you ever attempted suicide? Yes No If Yes, describe event and date:

____

Women Only:
YES NO
[ ] [ ] Are you pregnant? Due Date:__________ # of Pregnancies ________
[ ] [ ] Do you have severe menstrual cramps?_____ # of Miscarriages ____
[ ] [ ] Do you have severe mood swings?_______ # of Abortions__________
[ ] [ ] Are you seeing a fertility specialist?_______ # of Live Births_________

Family Health History (anyone related genetically including children) **:**

Mood or anxiety disorders, psychotic disorders, substance abuse,ADD:

Chronic sleep disturbance, migraine headaches, thyroid disorders:

Seizure disorders, stroke, aneurysms, multiple sclerosis:

Other family health history:

Marital/Significant Relationship History

Spouse (including common-law) and Ex-Spouses	Date of Marriage/ Living Arrangement	Date of Divorce or Separation
______________________________	__________________	____________________
______________________________	__________________	____________________
______________________________	__________________	____________________

Spouse's Age:________ Education:______________ Occupation:______________

Family of Origin History

Father's Name:________________________ Age:_____ Occupation:___________

If deceased, cause and age of death:_______________________________________

Is Father remarried? Y N To Whom ____________________________________

Mother's Name:________________________ Age:_____ Occupation:___________

If deceased, cause and age of death:_______________________________________

Is Mother remarried? Y N To Whom ____________________________________

Are your parents?: Married__________ Divorced_________ Separated_________

Brothers and Sisters:

Name	Age	Marital Status	Name	Age	Marital Status

Who lives with you in your home?:

Name	Age	Relationship	Name	Age	Relationship

Legal History

Have you had legal issues due to alcohol use, drug use, or domestic violence?:

____

____

Other

Any other information that might be helpful?

____

____