NAME: _____ DATE: _____

Referred by? _____ Reason for seeking treatment? _____

SOCIAL HISTORY

Birthplace? _____ Where did you grow up? _____

Parents' occupations? _____ Did your parents divorce? [ ] Yes [ ] No

What degree(s) did you receive in school? _____

What is your current occupation? _____

Employer? _____ How many hours per week do you work? _____

What was your previous occupation? _____

If you are disabled, when did this occur? _____

Military history (branch, rank, years served, combat, type of discharge)? _____

_____

Are you: [ ] Single [ ] Living with partner [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Do you have children? [ ] Yes [ ] No What are their ages? _____

Who lives with you now (include age and relationship to you)? _____

_____

Do you feel safe at home? [ ] Yes [ ] No

Have you been a victim of abuse? Physical [ ] Yes [ ] No Emotional [ ] Yes [ ] No

Sexual [ ] Yes [ ] No

If yes to any of the above, please explain: _____

_____

What is your daily intake of caffeine and what type? _____

What is your usual alcoholic beverage? _____ How often do you drink? _____

NAME: _____ DATE: _____

What is your usual use of tobacco products? _____

What is your usual use of marijuana? _____

What is you usual use of other substances such as prescription medications for pain or anxiety? _____

What is your usual use of other substances such as cocaine, LSD, speed, ecstasy, heroin, methamphetamine, etc? _____

Have you ever been in trouble with the law (excluding minor traffic violations)? Yes [ ] No [ ]

If yes, please explain: _____

What are your hobbies/interests? _____

Religious affiliation? _____

Do you exercise? Yes [ ] No [ ] Type, duration and how often? _____

MEDICAL HISTORY

List any current medical problems: _____

_____

_____

List any past medical problems (cancer, heart or lung disease, sexually transmitted diseases, etc.): _____

_____

Surgeries: _____

Medical Hospitalizations: _____

Medication Allergies: _____

Primary Care Provider: _____ Last Physical: _____

NAME: _____ DATE: _____

Head Injury? Yes [ ] No [ ] Loss of Consciousness? Yes [ ] No [ ] Seizures? Yes [ ] No [ ]

Meningitis? Yes [ ] No [ ] Abnormal Birth or Development? Yes [ ] No [ ]

If yes to any of the above, please explain: _____

_____

Are you satisfied with your current sexual activity? Yes [ ] No [ ]

Male partners in the last 5 years? _____ Female partners in the last 5 years? _____

Do you have any questions about safe sexual practices? _____

Have you ever had an HIV test? Yes [ ] No [ ] If yes, how long ago? _____ Result? _____

Height? _____ Weight? _____ Highest adult weight? _____ Lowest adult weight? _____

Do you have any concerns about your eating habits, diet or weight management? _____

_____

List any current medications you take including over-the-counter medications, vitamins, herbs, supplements and birth control.

Medication	Strength	How often?	Medication	Strength	How often?
1			5		
2			6		
3			7		
4			8		

List any past medications taken to treat psychiatric problems (depression, anxiety, mood swings, insomnia, etc). If you are able to, please include maximum dose taken and how long you were taking each medication: _____

_____

_____

NAME: _____ DATE: _____

FAMILY HISTORY

List any known family history of psychiatric problems including depression, anxiety, mania, Schizophrenia, suicide attempts, legal problems, alcohol abuse and drug abuse: _____

_____

_____

_____

List any known family history of medical problems: _____

_____

_____

_____

NAME: _____ DATE: _____

Please mark any of the following symptoms you have experienced within the past six months

Allergies:	____ Seasonal	____ Medication	____ Other: _____	
Blood:	____ Anemia	____ Bleeding Disorders		
Skin:	Change in:	____ Moles	____ Moisture	____ Texture
	Do you have:	____ Bleeding	____ Itching	____ Scaling
		____ Lesions	____ Easy Bruising	
Hair:	____ Loss	____ Excessive Growth		
	____ Change in Texture or Distribution			
Glands:	____ Pain	____ Drainage	____ Enlargement	
Head:	____ Trauma			
Eyes:	____ Infection	____ Trauma	____ Color Blindness	
	____ Loss of Vision	____ Retinoplathy	____ Retinal Detachment	
Ears:	____ Pain	____ Infection	____ Ringing	
	____ Loss of or Decrease in Hearing			
Nose:	____ Nose Bleeds	____ Runny Nose	____ Nasal or Sinus Infection	
Mouth:	____ Pain	____ Infection	____ Excessive Tongue Movement	
	____ Difficulty Chewing		____ Excessive Salivation	
Throat:	____ Trauma	____ Hoarseness	____ Pain or Difficulty Swallowing	
	____ Frequent Sore Throat		____ Change in Voice	
Neck:	____ Trauma	____ Pain	____ Limitation of Movement	
	____ Weakness	____ Stiffness		

NAME: _____ DATE: _____

Breast: ____ Skin Lesions ____ Lumps ____ Change in Skin Color

____ Nipple Discharge ____ Change in Size

Endocrine: ____ Abnormal Body Growth or Body Configuration

____ Excessive Sweating/Decrease in or Loss of Sweating

____ Increased Thirst, Hunger or Urination

____ Infertility or any Other Hormonal Abnormality

____ Heightened or Decreased Sensitivity to Hot or Cold

Cardiovascular: ____ Angina ____ Cold Hands or Feet

____ Palpitations ____ Irregular Heart Rate or Rhythm

____ Pain in Legs after Walking ____ Swelling of Hands or Feet

____ Shortness of Breath after Exercise

____ Shortness of Breath at Night before Falling Asleep

____ Shortness of Breath at Night that Awakens You

Respiratory: ____ Asthma ____ Coughing ____ Night Sweats

____ Sputum Production (Coughing up Mucus

____ Shortness of Breath at Rest ____ Lung infections

____ Shortness of Breath after walking how many Blocks? ____

Gastrointestinal: ____ Nausea ____ Change in Bowel Habits

____ Belching ____ Vomiting ____Change in Bowel Movements

____ Gas ____ Blood in Stool ____ Jaundice (Yellow Skin)

General: ____ Easily Fatigued ____ Fatigued upon Waking up

____ Fatigued only after Exercise ____ Excessive Weight Gain

NAME: _____ DATE: _____

Genitourinary: ____ Change in Color of Urine ____ Decreased Urination

____ Painful Urination ____ Frequent Urination at Night

____ Increased Urination ____ Erectile Dysfunction

____ Change in Menstrual Cycle

Skeletal: ____ Scoliosis ____ High Arched Feet

Neurological: ____ Loss of Smell ____ Loss of Taste ____ Double Vision

____ Dizziness ____ Falls ____ Balance Difficulty

____ Difficulty Chewing ____ Swallowing Problems

____ Excessive Eye Movement ____ Speech Problems

____ Decreased Facial Sensation ____ Loss of General Sensation

____ Generalized Weakness of Muscles

____ Sensation of Heavy Eyelids or Difficulty Holding Eyelids Open

____ Muscle Paralysis (Inability to Move Any Particular Muscle)

Please Describe: _____

____ Decrease in Muscle Size (Specify Where: _____)

____ Decrease in Muscle Strength (Specify Where: _____)

____ Involuntary Movement such as Shaking, Twitching or Spasms

____ Decreased or Increased Sense of Touch

____ Burning Pain ____ Numbness ____ Tingling ____ Headaches

____ Muscle Pain, Swelling or Tenderness (Specify Where: _____)

____ Easily Fatigued Muscles when Exercising

____ Muscle Cramps ____ Excessive Sweating

NAME: _____ DATE: _____

Neurological: (continued)

____ Inability to Control Urine or Bowels ____ Depression

____ Impotence ____ Loss of Early Morning Erections ____ Mood Swings

____ Memory Loss ____ Difficulty Concentrating ____Seizures

____ Blackouts ____ Uncontrollable or Inappropriate Crying or Laughing

____ Excessive Sleeping (Hyper Somnolence)

____ Inability to Sleep (Insomnia) ____ Fainting Spells

____ Lightheadedness

____ Lower Back Pain (Specify: With or Without Radiation to Legs? _____)

____ Neck Pain (Specify: With or Without Radiation to Arms? _____)