

LIST OF SYMPTOMS

Depressed Mood	Unexplainable Weeping	Excessive worrying	Distrust
Shortness of breath	Restlessness or fidgety	Fatigue or low on energy	Hallucinations
Frequent headaches	Nervousness	Inflated self-esteem	Confusion
Legal problems	Racing thoughts	Gastrointestinal problems	Irritability
Impulsivity	Work/School problems	Rapid heart beat	Nightmares
Overeating	Emotionally numb	Fear of losing control	Flashbacks
Blackouts	Phobia or fears	Fear of illness or dying	Loneliness
Low Self-esteem	Interpersonal conflict	Feelings of shame or guilt	Hyperventilating
Excessive sleep	Memory impairmnt L.T.	Marriage/Family Problems	Poor appetite
Numbness/tingling	Sexual acting out	Disassociating from self	Dizziness
Angry outbursts	Trembling or shaking	Fear of intimacy	Insomnia
Sexual Dysfunction	Secretive/bizarre behavr	Poor concentration	Stress
Obsessive thoughts	Social withdrawal	Cravings for Drugs/Alcohol	Repetitive Rituals
Weight loss	Oppositional behavior	Disassociating from environment	Risky behavior

List your prescribed drugs and over-the-counter drugs, such as vitamins or herbals

Name the Drug	Dose/frequency	Pathology for which it is prescribed

List drugs of abuse, excluding alcohol but including over-the-counter & abused prescriptions

Name of Drug	Age 1 st used	Last use date	Amount, Frequency and route of use when last using

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

EXERCISE

- Sedentary (No exercise)
- Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
- Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
- Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)

DIET	Are you dieting? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If yes, are you on a physician prescribed medical diet? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you snack? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Rank salt intake <input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
	Rank fat intake <input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
ALCOHOL	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you tried to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No When?
	How many days per week? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7	Have you any history of blackouts? <input type="checkbox"/> Yes <input type="checkbox"/> No
	How many drinks per day? <input type="checkbox"/> 1 <input type="checkbox"/> 2 - 4 <input type="checkbox"/> 5 - 9 <input type="checkbox"/> 10+	If yes, what kind?_
	Are you prone to "binge" drinking? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your drinking concern you? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Do you drive after drinking? <input type="checkbox"/> Yes <input type="checkbox"/> No
TOBACCO	Are you currently smoking? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you tried to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No When?
	<input type="checkbox"/> Cigarettes - pks./day ____ <input type="checkbox"/> Vape - #/day ____ <input type="checkbox"/> Chew - #/day ____ <input type="checkbox"/> Pipe - #/day ____ <input type="checkbox"/> Cigars - #/day ____	
	Have you considered cutting back? <input type="checkbox"/> Yes <input type="checkbox"/> No	Age you 1 st began to smoke?
SEXUALITY	Are you sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No	Any discomfort with intercourse?
	List contraceptive/barrier method used: <input type="checkbox"/> None <input type="checkbox"/> IUD <input type="checkbox"/> Pill <input type="checkbox"/> Condom	
	List any sexually transmitted disease you have had: <input type="checkbox"/> None <input type="checkbox"/> Herpes <input type="checkbox"/> Syphilis <input type="checkbox"/> HPV <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Hepatitis C	
Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your therapist about your risk of this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No		
SAFETY	Have you ever seriously thought about hurting yourself? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Have you ever attempted suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, are you trying for a pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you any thought of killing someone else?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?		

MEDICAL HISTORY

Skin disorder	Heart or circulation problem	RECENT CHANGE IN ANY BELOW:	
History of head injury	Severe chronic pain		Weight
Ears, nose or throat problem	Gastrointestinal problem		Energy level
Diabetes	Bladder		Ability to sleep
Multiple sclerosis	Hormonal imbalance		Control of bladder or bowel movement
Thyroid or adrenal gland problem	Viral or bacterial infection		B vitamin level
Epilepsy	Cancer		Hormone balance
Stroke	Recent pregnancy		Other pain/discomfort:

FAMILY OF ORIGIN HISTORY

PLEASE LIST ANY MENTAL HEALTH OR SUBSTANCE ABUSE HISTORY (IF YOU'RE UNCERTAIN BUT SUSPECT A PROBLEM, MAKE NOTE OF THIS) OF EACH MEMBER OF THE FAMILY IN WHICH YOU GREW UP.

NOTE IF STEP OR ADOPTIVE	MENTAL HEALTH & SUBSTANCE ABUSE HISTORY	SIBLING NAMES	SEX	AGE	MENTAL HEALTH & SUBSTANCE ABUSE HISTORY
Mother			<input type="checkbox"/> F <input type="checkbox"/> M		
Father			<input type="checkbox"/> F <input type="checkbox"/> M		
Grandmother <i>Maternal</i>			<input type="checkbox"/> F <input type="checkbox"/> M		
Grandfather <i>Maternal</i>			<input type="checkbox"/> F <input type="checkbox"/> M		
Grandmother <i>Paternal</i>			<input type="checkbox"/> F <input type="checkbox"/> M		
Grandfather <i>Paternal</i>			<input type="checkbox"/> F <input type="checkbox"/> M		

CURRENT FAMILY HISTORY

CURRENT Significant Other	MENTAL HEALTH & SUBSTANCE ABUSE HISTORY	CHILDRENS NAMES	SEX	AGE	MENTAL HEALTH & SUBSTANCE ABUSE HISTORY
			<input type="checkbox"/> F <input type="checkbox"/> M		
Past Significant Other			<input type="checkbox"/> F <input type="checkbox"/> M		
			<input type="checkbox"/> F <input type="checkbox"/> M		
			<input type="checkbox"/> F <input type="checkbox"/> M		
			<input type="checkbox"/> F <input type="checkbox"/> M		

LEGAL HISTORY

PLEASE LIST HISTORY OF ARRESTS, CONVICTIONS, AND INCARCERATIONS, AS WELL AS CURRENT PROBATION/PAROLE.

Do you have any outstanding warrants?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Upcoming trial?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
CRIME	ARRESTED?	CONVICTED?	IMPRISONED?	LENGTH OF PAROL?	LENGTH OF PROBATION?
	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	__ mnths __ yrs	__ mnths __ yrs	__ mnths __ yrs
	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	__ mnths __ yrs	__ mnths __ yrs	__ mnths __ yrs
	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	__ mnths __ yrs	__ mnths __ yrs	__ mnths __ yrs

EDUCATIONAL HISTORY

Highest level of education completed:	<input type="checkbox"/> 8 th grade <input type="checkbox"/> GED <input type="checkbox"/> high school <input type="checkbox"/> 1+ year of college <input type="checkbox"/> college				
<input type="checkbox"/>	Not very social	<input type="checkbox"/>	Very popular	<input type="checkbox"/>	Advanced classes
<input type="checkbox"/>	High achiever, in college	<input type="checkbox"/>	Participated in extracurricular activities	<input type="checkbox"/>	Behavioral problems
<input type="checkbox"/>	Played sports in school	<input type="checkbox"/>	Special education classes	<input type="checkbox"/>	

VOCATIONAL HISTORY

OCCUPATION/JOB TITLE	PERIOD OF EMPLOYMENT	LAID OFF?	FIRED?	JOB LOSS DUE TO:	
				ETOH/DRUGS?	MENTAL ILLNESS?
	From: ____ To: _____	Yes No	Yes No		

