Contact info Date ________________

Name ____ DOB _______________

☐ Male ☐ Female Insurance Number: ______________________________

☐ Single ☐ Married ☐ Divorced

☐ Employed full-time ☐ Employed part-time ☐ Retired ☐ Student

Address ____

____

Phone (home) ________________________ (cell) _________________________

Phone (work) ________________________ (other) _________________________

Email ____

Text ____

How do you prefer to be contacted? _______________________________________

Emergency contact ____

Phone (home) ______________________ (cell) _____________________

Relationship____

Reason or motivation for services.

____

____

____

How long has this been a problem? _________________________________

Referred by ____ and/or

How did you find me? ____

Insurance Authorization number (if applicable) _______________________________

MEDICAL HISTORY

Do you have any allergies? No Yes Allergic to: ____

Name of primary physician____

City: _________________________________

Phone: ________________________________ Date of last exam: ___________________

Are you on medications for any medical condition? No Yes

Name of medication: ______________________________ For what condition? __________________

Name of medication: ______________________________ For what condition? ___________________

Name of medication: ______________________________ For what condition? ___________________

Have you ever been hospitalized? No Yes For what condition? _________________________________

MENTAL HEALTH HISTORY

Have you ever seen a psychiatrist or therapist? No Yes For what condition?_________________________

When?____

With whom?____

Have you ever been on medication prescribed by a psychiatrist? No Yes

Name of medication: ____________________ When?______________ Any negative reactions? No Yes

Name of medication: ____________________ When?______________ Any negative reactions? No Yes

Name of medication: ____________________ When?______________ Any negative reactions? No Yes

Have you ever considered suicide? No Yes When? ____

Have you ever attempted suicide? No Yes When?____

Have you done any form of self-harm? No Yes When and how? _________________________________

____

FAMILY HISTORY

Please check all that apply to immediate family?

Drug Abuse	No Yes	Suicide	No Yes	Attention Problems	No Yes
Alcohol Abuse	No Yes	Psychiatric Hospitalizations	No Yes	Learning Problems	No Yes
Depression	No Yes	Psychiatric Medications	No Yes	Manic Depression	No Yes
Suicide Attempts	No Yes	Therapy or Counseling	No Yes Sí	Schizophrenia	No Yes

Are you adopted? No Yes At what age?___________________________

Is there adoption or foster care in your immediate family? ____

Is there adoption or foster care in your extended family? ____

Have there been any events in your life, which you consider to have been traumatic? No Yes

____

____

EDUCATION HISTORY

Education level: Preschool K 1 2 3 4 5 6 7 8 9 10 11 12

Some college College degree Graduate school

SUBTANCE USE

Tobacco Use: ______ past ______ present ______ a day ______a week ______a month

Caffeine Use: ______ past ______ present ______ a day ______a week ______a month

Alcohol Use: ______ past ______ present ______ a day ______a week ______a month

How often to excess? Always Usually Sometimes Occasionally Never

Illicit Drug Use: _________ past _________ present

Which drug? ______________________________ How often? _____ day _____ week _____ month

Which drug? ________________________________ How often? _____ day _____ week _____ month

Which drug? ________________________________ How often? _____ day _____ week _____ month

SOCIAL SUPPORTS

What are your hobbies? ____

What do you do for fun? ____

Are you involved in any clubs or sports? ____

Religion or Spiritual faith ____

Are you involved in any church or synagogue? ____

Do you volunteer? ____

Any other affiliations? ____

Who do you consider are part of of your support system?

____

____

____

Disability:
Do you have a disability? Yes No If yes, please specify: ___________________________________
If you have a disability, does the office accommodate your needs? Yes No
If no, please explain:
____

Optional:

Race:

White/Caucasian Asian
American Indian or Alaska Native Black/African American
Native Hawaiian or Pacific Islander Hispanic
Two or more races Unknown

Ethnicity, Heritage or Culture that you identify with:
____

Any other significant information you would like to share?

____

____

____