



Name _____

DOB _____

Today's Date _____

Briefly describe your reason(s) for seeking help:

How long have you had the problem(s)?

Why did you decide to seek help now?

What other ways have you tried to deal with this problem?

History of treatment for emotional problems and family history

Outpatient treatment Yes No

Did it help? Yes No

Therapist's name _____

Dates in treatment _____

Inpatient treatment Yes No

Where _____

When _____

How long _____

Family history of emotional problems Yes No

Who _____

Circle any of the following items that apply to you:

- | | | | |
|--------------------------|---------------------------------------|------------------------|-------------------------|
| Thoughts of suicide | Thoughts of harming others | Phobias/Fears | Ongoing Pain |
| Trouble getting to sleep | History of attempts to kill yourself | Panic/Anxiety attacks | Substance Abuse |
| Waking during the night | Cutting or otherwise hurting yourself | Excessive guilt | Grief |
| Waking early every day | Feelings of hopelessness | Forgetfulness | Irritability |
| Financial problems | Inability to make decisions | Mood swings | Social Isolation |
| Loss of appetite | Trouble controlling your temper | Health problems | Sexual Issues |
| Hearing voices | Large weight gain or loss | Family problems | Obsessive Thoughts |
| Problems at work | Seeing things others don't | Violence toward others | Compulsive Behaviors |
| Trouble concentrating | History of physical abuse | Lack of Motivation | History of sexual abuse |
| Racing thoughts | Depressed mood | Frequent Crying | Worry |
| Legal problems | History of emotional abuse | Anxiety | |

Health Status

List any medical problems or physical problems and when they were diagnosed:

List any major (where you were put to sleep) surgeries you have had to date:

List any serious illness or injuries, including any head injuries:

List all allergies to foods or drugs:

Date of last physical examination _____ Doctor's name _____

Drug and Alcohol Information

List all prescription and over-the-counter drugs you are taking:

Circle substances you use in any amount at all

	Age first used	How much do you use per			Last used
		Weekday	Weekend	Month	
Beer	_____	_____	_____	_____	_____
Liquor	_____	_____	_____	_____	_____
Wine	_____	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____	_____
Cocaine/Crack	_____	_____	_____	_____	_____
Meth/Crystal	_____	_____	_____	_____	_____
Heroin	_____	_____	_____	_____	_____
Barbiturates/Downers	_____	_____	_____	_____	_____
PCP/LSD/Hallucinogens	_____	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____	_____
Other _____	_____	_____	_____	_____	_____

To be completed by adults (18 yrs and older)

- Have you ever felt like you should cut down on your drug or alcohol use? Yes No
- Has a friend or relative expressed concerns about your use? Yes No
- Have you ever felt guilty about your drinking or drug use? Yes No
- Have you ever had to take a drink or use a drug the next day to steady your nerves? Yes No
- Are you a recovering alcoholic or a recovering drug addict? Yes No
- Is there a history of problems with drug or alcohol use in your family? Yes No

To be completed by adolescents (12 yrs to 17 yrs)

- Have you ever used alcohol or drugs before or during school? Yes No
- Have you ever missed school (or been late) because of use? Yes No
- Have you ever avoided non-users? Yes No
- How often do you get drunk/high? _____
- About how often do you use more than one drug when you get high? _____
- Is there a history of problems with drug or alcohol use in your family? Yes No

Client signature _____ Date _____ Therapist Signature _____ Date _____