

YOUR NAME: _____ Age: _____ Today's Date: _____

Referred by - Name: _____ Agency: _____ May I send thank-you? Yes No

Primary Physician's Name: _____ Phone#: _____ Last Exam: _____

Practice Name: _____ Location: _____

Relevant medical history/allergies: _____

Current medications (including birth control): _____

Past long-term medications: _____

Would you like your physician to know that you are coming to therapy, and your progress here? Yes No

Previous therapist: _____ Approx. # sessions: _____ When: _____

Previous therapy issues: _____

Previous therapist: _____ Approx. # sessions: _____ When: _____

Previous therapy issues: _____

Hospitalizations: Mental health Chemical Dependency When: _____

Religious affiliation: _____ Religion's importance to you: Not at all Somewhat Very

Have you had thoughts of suicide in the last month? Yes No Have you had plans/attempts? Yes No

RELATIONSHIP STATUS: Single Married/Partnered Separated Divorced Widowed

of Marriages/Long term Partnerships & length/dates: _____

OTHER ADULT(S) WHO LIVE WITH YOU:

Name: _____ M F Age: _____ Relationship: _____ Length: _____

Name: _____ M F Age: _____ Relationship: _____ Length: _____

YOUR SIGNIFICANT OTHER (if not living with you):

Name: _____ M F Age: _____ Relationship: _____ Length: _____

PLEASE LIST ALL CHILDREN:

Name: _____ M F Age: _____ Rel'nshp: _____ Live w/you? Y N

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Name: _____ M F Age: _____ Rel'nshp: _____ Live w/you? Y N

Name: _____ M F Age: _____ Rel'nshp: _____ Live w/you? Y N

SUBSTANCE USE HISTORY	Amount used and frequency <i>IN LAST MONTH</i> example: 3 beers per day (NOW)	None	Amount used, frequency and dates <i>WHEN YOU USED IT THE MOST</i> example: 6 beers per day in 1991	
				Never Used
Coffee-tea-caffeinated soda				
Cigarettes				
Alcohol				
Marijuana				
Cocaine				
Amphetamines (uppers)				
Barbiturates (downers)				
Tranquilizers				
Hallucinogens				
Opiates				
Other _____				

The primary problem that has brought you to therapy: _____

The goals you hope to achieve in therapy: _____
