

Patient: _____

Date: _____

- Concentration/Memory Difficulties _____
- Increased Sexual Interest _____
- Decreased Sexual Interest _____
- Decreased Appetite _____
- Increased Appetite _____
- Difficulty Falling Asleep _____
- Early Morning Awakening _____
- Difficulty Staying Asleep _____
- Excessive Sleeping _____
- Suicidal Thoughts _____
- Thoughts of Harming Others _____
- Anxious/Worried _____
- Panic Attacks _____
- Fear of Leaving the House _____
- Fear of Driving _____
- Fear of Specific Situations or Things _____
- Fear of Embarrassing Oneself in Public _____
- Intruding, Uncomfortable, Upsetting Thoughts _____
- Repetitive Thoughts or Behaviors _____
- Excessively Orderly and Perfectionistic _____
- Periods of "Lost" Time _____
- Excessive Anger / Aggressiveness _____
- Difficulty Trusting Others _____
- Binging/Purging _____
- Rebellious/Defiant _____
- Victim of Abuse or Trauma: _____
 - Emotional _____
 - Sexual _____
 - Physical _____
- Offender of abuse: _____
 - Emotional _____
 - Sexual _____
 - Physical _____

OFFICE USE ONLY

Patient: _____

Date: _____

Do any of the people in your current living situation have a mental health, alcohol or drug problem? If yes, please list and describe.

Use the table below to describe the people in your current living situation.

Name	Relation to Yourself	Age	Education/ Occupation	Personal Style

Describe your current employment and financial situation:

Describe any relevant legal issues:

Describe any other relevant stressors:

Do any of the people in your family of origin currently or in the past have a history of mental health, alcohol, or drug problems? If yes, please list and describe.

OFFICE USE ONLY

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Date: _____

Use the table below to describe the people in your family of origin.

Name	Relation to Yourself	Age	Education/ Occupation	Personal Style

OFFICE USE ONLY

Please check any of the following medical issues that apply to your situation. Add comments if necessary:

- Blood Pressure Problems _____
- Diabetes _____
- Thyroid _____
- Heart _____
- Lungs _____
- Kidney _____
- Stomach _____
- Seizures _____
- Headaches _____
- Other _____

Who is your Primary Care Doctor? _____

Date of your most recent physical? _____

Date of your most recent blood work? _____

Ever had EEG, CT, MRI, of the head? _____

Any abnormal findings?

List all current medications:

Allergies (include medication allergies):

Patient: _____ Date: _____

Please complete the following table and answer the questions below. Add comments if necessary:

Substance Use:

Substance	Age @ First Use	Use Last 30 Days	Average Quantity Per Use	Last Used	Amount Used
Alcohol					
Sedatives/Barbituates					
Heroin (Opioids)					
Cocaine					
Other Stimulants					
Marijuana					
Halucinagenics					

No Yes Someone in the biological family has or has had a serious substance abuse problem.

No Yes In the past two years, there has been one or more episodes of memory loss due to substance abuse.

No Yes There are personality changes due to the use of substances.

No Yes In the past 5 years, there has been one or more arrest with a B.A.L. of .16% or higher.

No Yes Someone close to you thinks you may have a serious substance use problem.

No Yes In the past year there has been an out of control experience due to substance use.

No Yes There is a history of serious problems with the use of substances.

No Yes There is a history of substance abuse treatment (may include 12-step program).

Comments:

