

To help us understand better what concerns you may have, please circle any of the following problems which pertain to you:

Nervousness	Depression	Fears
Shyness	Sexual Problems	Suicidal Thoughts
Separation	Divorce	Finances
Drug Use	Alcohol Use	Friends
Anger	Self-Control	Unhappiness
Sleep	Stress	Work
Relaxation	Headaches	Tiredness
Legal Matters	Memory	Ambition
Energy	Insomnia	Making Decisions
Loneliness	Inferiority Feelings	Concentration
Education	Career Choices	Health Problems
Temper	Nightmares	Marriage
Children	Appetite	Stomach Trouble
Bowel Troubles	Being a Parent	My Thoughts

Some managed care companies require we ask the following questions regarding cultural/spiritual issues. You may choose to respond or not respond.

1. With what ethnic/cultural/racial group do you identify? _____
 2. What is your religious affiliation? _____
 3. What role does your religion/spirituality play in your life?
__ Positive __ Negative __ Neutral
 4. Are there any spiritual or cultural issues that you feel need to be taken into account in your treatment? ____ Yes ____ No If yes, please identify? _____
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DIET, SUBSTANCE USE AND LIFE STYLE ISSUES

1. Are you on a special diet? No Yes
Describe _____

2. Current caffeine consumption (Soda, Coffee, Tea, Iced Tea, Etc)? No Yes
Amount _____

3. Do you take Over The Counter (OTC) medications, herbal preparations, dietary supplements, etc? No Yes Type _____

4. Do you drink alcohol? No Yes
Type _____ Amount _____ Last Drink _____

5. Have you ever had a problem with alcohol? No Yes
Describe _____

6. Do you use any illicit drugs, e.g. marijuana, cocaine, hallucinogens, etc? No Yes
Type _____ Amount _____ Last Used _____

7. Have you ever had a problem with substance abuse (other than alcohol)? No Yes
Describe _____

8. Have you ever experienced unprotected sex, needle sharing, or blood transfusion?
 No Yes Describe _____

9. Do you use tobacco in any form?
No Yes Describe _____

10. Have you ever received mental health or substance abuse treatment? None
Inpatient Outpatient
Place/Provider _____ Year(s) _____ Reason _____
Place/Provider _____ Year(s) _____ Reason _____
Place/Provider _____ Year(s) _____ Reason _____
Place/Provider _____ Year(s) _____ Reason _____
Place/Provider _____ Year(s) _____ Reason _____

11. When were you last seen by a mental health professional?
_____ N/A

12. Please list your family doctor and any other physicians or therapists involved in your care.

13. Do you have any health problems? No Yes

Please list:

_____	_____
_____	_____
_____	_____

14. Have you had any major, non-psychiatric hospitalization? No Yes

Place Year Reason

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

15. Have you any drug allergies or sensitivities? No Yes

Please list:

Drug Symptom

_____	_____
_____	_____
_____	_____

16. Have you any other allergies or sensitivities (e.g. environmental, food, dye, latex, etc)

No Yes Describe _____

17. Do you take any medications, currently? No Yes

Drug Dose Frequency Duration Reason

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

18. In the past, have you ever been on medication for anxiety, depression, insomnia, etc?

No Yes

If yes,

Drug When How Long Effectiveness Side Effects Why Discontinued

19. Do you have any family history for mental illness or substance abuse? No Yes

Describe _____

20. Do you have any family history for medical problems, including diabetes, heart disease, cancer, Alzheimer's, asthma, etc? No Yes If Yes, describe

Signature

Date