VITALS: HEIGHT_____ WT_____ BP_____ PULSE_____

NAME_____DATE:_____

In your own words, please describe the reason for this visit and your current difficulties:

_____

When did these symptoms begin: _____Goals for treatment:_____

Is there anything that makes these symptoms better/ worse: _____

How is this affecting your life (relationships, job, school, and/or health:)

_____

PSYCHIATRIC HISTORY: Do you have any other Mental Health Diagnoses? YES NO (if yes please describe)

_____

Please list other Mental Health Providers: _____

Have you ever been hospitalized for Mental Health illness? YES NO (if yes, list when and where)

_____

Have you ever attempted suicide? YES NO Have you ever been to substance abuse program? YES NO (if yes when and where _____

Have you ever used, or do you currently use any of the following: (mark all that apply)

Nicotine/Tobacco Alcohol Marijuana Meth Crack/ Cocaine Heroin Narcotics/Pain killers

Other illicit Drugs: _____Have you ever injected a drug? YES NO

Do you smoke cigarettes? YES NO Chewing Tobacco? YES NO

Electronic cigarettes? YES NO Nicotine Gum/Patch? YES NO

If yes, when did you first start, and how much per day? _____

MEDICAL HISTORY: PCP_____

Diabetes High Blood Pressure High Cholesterol Seizure Disorder Hepatitis Thyroid Problems

Chronic Pain Serious Head Injuries Other Medical Problems: _____

List all Surgeries (and year): _____

List all current medications: _____

Do you have any allergies: YES NO If yes, please list medication and effect:

_____

FAMILY HISTORY: Is there anyone in your family with (mark all that apply):

Depression Anxiety Bipolar Disorder Post-traumatic Stress Schizophrenia Anger/Violence ADHD

Autism Eating disorder Learning, developmental / intellectual differences Legal Problems

Does anyone in your family have a drug or alcohol problem? YES NO

Has anyone in your family committed suicide? YES NO

History of medication use: _____

VITALS: HEIGHT_____ WT_____ BP_____ PULSE_____

NAME_____DATE:_____

SOCIAL HISTORY: Where were you born and raised? _____

In Elementary, Junior High, or High School, what type of classes did you attend? _____

Regular, mainstream classes Advanced classes Special Education classes

Highest Level of Education: Some High school High school diploma GED some college

2yr/Associates 4yr/Bachelor's Master's Degree Trade School/Other_____

Marital Status: Single, never married Married Separated Divorced Widowed

Any Children? YES NO If yes, how many? _____, please list gender and age below

Gender_____Age_____; Gender_____Age_____; Gender_____Age_____;Gender_____Age;

Gender_____Age_____

Who do you currently live with? _____

EMPLOYMENT: Employed Unemployed Retired Disabled **Occupation**: _____

Income: Employment SSI SSDI Pension Other _____

Have you ever been a victim of physical or sexual abuse or trauma: YES NO

Have you ever been arrested or imprisoned: YES NO

Do you currently have a case manager? YES NO If yes, who? _____

Do you have access to any guns/firearms? YES NO

Were you ever in the military? YES NO If yes, what branch and highest rank? _____

Cultural and Religions Considerations: _____

Physical Symptoms as of TODAY:

Fatigue Weight change Fever Chills Sudden Vision Changes Sinus problems Sudden Hearing Changes
Ringing in your Ears Throat problems Cough Low Sex Drive Chest pain/discomfort Shortness of Breath
Frequent Urination Difficulty Starting Urine Stream Drive Erectile Dysfunction Nausea
Vomiting Diarrhea Constipation Muscle or Joint Pain Cold Intolerance Numbness/Tingling
Heat Intolerance Women: Unusual discharge or bleeding Menopause Date of last period: _____
Other:_____