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Intake Information

Name: _____ Date: _____

Date of birth: _____ Age: _____

Marital Status: (check one) single engaged married separated divorced
 widowed living with someone remarried

Do you live in: house room apartment other

With whom do you live: (check all that apply) self parents spouse roommate
 child/children friend other (specify) _____

Have you been hospitalized for medical issues before? yes no

If so, please list approximate dates and reasons:

Have you been hospitalized for psychological, psychiatric or substance dependence issues before?

yes no If so, please explain: _____

Does any member of your family suffer from psychological, psychiatric or substance dependence issues? yes no

Social History

Father: name _____ age if living _____

Occupation: _____ health _____

If deceased, give his age at time of death _____ your age at that time _____

Mother: name _____ age if living _____

Occupation: _____ health _____

If deceased, give her age at time of death _____ your age at that time _____

Siblings: Ages of brothers: _____

Ages of sisters: _____

If you were not raised by your parents, who raised you and between what ages? _____

Check any of the following that applied during your childhood/adolescence:

___ happy childhood

___ not enough friends

___ unhappy childhood

___ school problems

___ emotional/behavioral problems

___ financial problems

___ legal trouble

___ strong religious convictions

___ death in family

___ alcohol/drug abuse or dependence

___ medical problems

___ severely punished

___ ignored

___ sexually abused

___ eating disorder

___ other: _____

List any medications you are currently taking: _____

List any significant medical problems that apply to you:

Do you get regular physical exercise: ___yes ___no

How much alcohol do you drink? _____ daily _____ weekly

Do you feel that you are a healthy eater? ___yes ___no

Please describe briefly the primary reason you have sought out an appointment and the goals you wish to achieve:
