Name: _____
DOB: _____

Medical Section

List any previous psychiatric (or alcohol and/or drug treatment) hospitalizations:

Reason for Treatment	Hospital/Place	Treatment Date	Length of Treatment

List any medical or surgical (operations) hospitalizations:

Reason for Treatment	Hospital/Place	Treatment Date	Length of Treatment

Please check the following illness(es) or conditions you have been treated for by a physician:

_____ Anemia
_____ Arthritis
_____ Asthma
_____ Bleeding from mouth/rectum
_____ Cancer
_____ Diabetes
_____ Emphysema
_____ Epilepsy or seizures
_____ Frequent headaches
_____ Gastritis
_____ Glaucoma or eye disease
_____ Hearing loss
_____ Heart attack
_____ Heart Disease
_____ Other problems not listed above: _____

_____ Hemorrhoids
_____ Hernia – type _____
_____ High blood pressure
_____ Kidney problems
_____ Liver disease
_____ Pancreatitis
_____ Prostate problems
_____ Skin problems
_____ Thyroid disorder
_____ Tuberculosis (TB)
_____ Ulcers
_____ Venereal disease
_____ Weight change
_____

_____

_____

What medications are you taking, how much, and how often?

Name	How much/often?	Name	How much/often?

Height: _____ Maximum Weight: _____

Current Weight: _____ Ideal Weight: _____

Are you allergic to any medications? _____ YES _____ NO

If "YES" list the medicine name (type) and the reaction that you had:

Name (type)	Reaction	Name (type)	Reaction

Health habits (Check all that apply):

_____ Do you drink beer, wine, whiskey, or spirits?

_____ Have you ever felt that you should cut down on your drinking?

_____ Have people annoyed you by criticizing your drinking?

_____ Have you ever felt bad or guilty about your drinking?

_____ Have you ever had a drink in the morning to steady your nerves or to get rid of a hangover?

_____ Have you ever had a ticket while intoxicated? If "yes", how many times?

Times? _____ When? _____

How frequently do you drink?

_____ Daily _____ Twice/week _____ Monthly _____ Other: _____

Do you now, or have you in the past, used marijuana or any other street drug? _____ YES _____ NO

If "yes", what? _____ How often? _____ How long? _____

Do you use tobacco? _____ YES _____ NO If "yes", what, how long, and how much?

Cigarettes/day _____ Pipe/day _____

Cigars/day _____ Chew/dip _____

What is the total number of years you have smoked/chewed? _____

Do you drink coffee? _____ YES _____ NO

_____ Regular Number of cups per day? _____

_____ Decaffeinated Number of cups per day? _____

GENETIC SECTION

Please list any biological children:

First Name	Age	Sex (M,F)	Any health problems (Yes/No)? When?

Have any members of your family had mental problems or received mental health or alcohol and drug treatment?

_____ YES _____ NO

If "yes", please describe the symptoms each individual experienced and was treatment helpful:

Relation/Name	Symptoms	Treatment Helpful (Yes/No)

Work Section

Current income situation:

_____ Presently employed full time – Occupation _____

Where: _____ How long: _____

_____ Presently employed part time – Occupation _____

Where: _____ How long: _____

_____ Unemployed – How long: _____ Why: _____

_____ Retired – When _____

_____ Disabled (cannot work) Type of disability _____

_____ Student – What grade/level _____

Psychological Section

List your strong points: _____

_____

_____

Present interests, hobbies, and activities:

_____

_____

_____

List your goals in life: _____

_____

_____

Please list all problems (emotional, alcoholic, physical, family, marital, vocational, etc) which you are experiencing:

_____

_____

_____

_____

_____

Where do you see yourself in five (5) years: _____

_____

If a "magic genie" could grant me three wishes, I would ask for:

1. _____
2. _____
3. _____

List your five (5) main fears:

1. _____
2. _____
3. _____
4. _____
5. _____

If I could be anywhere in history, I would be: _____

Why? _____

Please check any of the following you have or have had:

_____ Loss of pleasure in previously enjoyed activities

_____ Sudden episodes of rapid heart beat or feeling that your heart is pounding loudly

_____ Sudden episodes of lightheadedness or feeling faint

_____ Sudden episodes of sweating/hot flashes or trembling

_____ Sudden episodes of chest tightness or a feeling of smothering or not being able to get enough air

_____ Anxiety	_____ Panic Attacks	_____ Memory change
_____ Change in Appetite	_____ Depression	_____ Change in weight
_____ Sleep disturbance	_____ Crying spells	_____ Thoughts of suicide
_____ Fatigue/low energy/weariness	_____ Suicide attempts	
_____ "Voices"/"Visions"	____ Sexual problems	_____Do you cry or laugh for no reason?

Dates: _____ Other: _____

Psych and Therapy Section

Please explain the nature of your main problem(s): _____

Please give a brief account of the history and development of your complaints from the onset (beginning) to present:

Why did you seek help this time? _____

What are you hopes for treatment? _____

PLEASE STOP HERE !!!

THANK YOU for completing this assessment form. The following pages will be added at the time of your clinical interview. The information provided is valuable and essential to determine the best clinical treatment just for YOU.