

Marital Status: S M Partnered W Div Sep Presently Living With: _____

Spouse's Name: _____ Date of Marriage: _____

Spouse's Occupation: _____ Dates of Previous Marriages (You): _____ (Spouse): _____

Is Your Father ___ Living ___ Deceased Age (or year he died): _____

Is Your Mother ___ Living ___ Deceased Age (or year she died): _____

Number of Brothers & Sisters: _____ Ages of Your Children: _____

Names of Emergency Contact: _____ Phone: _____

Please Briefly Describe Why You Are Seeking Services At This Time:

Current Medications: _____

Describe Current Health Status: _____ Approximate Date of Last Physical Exam: _____

Major Illnesses, Accidents, or Surgeries (include year): _____

Current & Previous Mental Health and or Substance Abuse Treatment, Including Medication: _____

Family History of Problems with Mental Health, Substance Abuse, Trauma, Etc. (including parents, spouse, children)

Personal Symptoms History

Check any that apply to you now. Place a "P" by those that have been problems in the past but are not problems now.

- | | | | |
|--|--|--|--------|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> School Problems | Other: |
| <input type="checkbox"/> Insomnia/Sleep Problems | <input type="checkbox"/> Feel Tense | <input type="checkbox"/> Work Problems | |
| <input type="checkbox"/> No Appetite | <input type="checkbox"/> Constant Worrying | <input type="checkbox"/> Financial Problems | |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Legal Problems | |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Excessive Fears | <input type="checkbox"/> Marital Problems | |
| <input type="checkbox"/> Can't Make Decisions | <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Relationship Problems | |
| <input type="checkbox"/> Low Self Esteem | <input type="checkbox"/> Excessive Guilt | <input type="checkbox"/> Physical Abuse | |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Over Ambitious | <input type="checkbox"/> Emotional Abuse | |
| <input type="checkbox"/> Inferiority Feelings | <input type="checkbox"/> Overly Suspicious | <input type="checkbox"/> Dislike Weekend/Holidays | |
| <input type="checkbox"/> Anger Problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Family Conflict | |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Recent Loss | |
| <input type="checkbox"/> Violent Behavior | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Childhood Trauma | |
| <input type="checkbox"/> Compulsive Behavior | <input type="checkbox"/> Seizures | <input type="checkbox"/> History of Sexual Abuse | |
| <input type="checkbox"/> Overeating | <input type="checkbox"/> Disorientation | <input type="checkbox"/> History of Sexual Assault | |
| <input type="checkbox"/> Weight Problems | <input type="checkbox"/> Memory Problems | <input type="checkbox"/> Flashbacks | |
| <input type="checkbox"/> Sexual Problems | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Excessive Alcohol Use | |
| <input type="checkbox"/> Sexual Preoccupation | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Drug Abuse | |
| <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Chronic Medical Problems | <input type="checkbox"/> Hallucinations | |
| <input type="checkbox"/> Past Suicidal Attempts | <input type="checkbox"/> Significant Childhood Illness | | |