

Mental Health Intake Form

(all information on this form is strictly confidential)

Patient First Name:	Patient Last Name:
Name of Person completing form (if other than patient):	
Date Completed:	Patient Date of Birth:
Primary Care Physician:	Physician Phone:

Current Symptoms Checklist (please check all appropriate columns)

	Mild	Moderate	Severe		Mild	Moderate	Severe
Aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Judgment errors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Agitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loneliness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of interest in activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Memory impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Change in libido	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obsessions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Compulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oppositional behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crying/tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cyber addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paranoia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Phobias/fears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical trauma perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disorientation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical trauma victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty getting out of bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty making decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distractibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Racing thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurring thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elevated mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Self-mutilation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional trauma perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional trauma victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual trauma perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual trauma victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grief	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Guilt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Speech problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gambling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Social isolation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing voices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Worthlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impulsivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL HISTORY

Current Medications

Medication Name	Total Daily Dosage	Estimated Start Date

Describe current physical health: Good Fair Poor

List any known allergies:

Past nonpsychiatric hospitalizations or surgeries:

Do you exercise regularly? Yes No

Personal and Family Medical History (Have you or a family member ever had any of the following? If family, specify which family member)

	You	Family	Who?		You	Family	Who?
Alzheimer's/Dementia	<input type="checkbox"/>	<input type="checkbox"/>		Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	
Anemia	<input type="checkbox"/>	<input type="checkbox"/>		Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>		High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	
Behavioral problems	<input type="checkbox"/>	<input type="checkbox"/>		HIV Positive or AIDS	<input type="checkbox"/>	<input type="checkbox"/>	
Birth defects	<input type="checkbox"/>	<input type="checkbox"/>		Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Liver Problems/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>		Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>		Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		Migraine or Cluster Headaches	<input type="checkbox"/>	<input type="checkbox"/>	
Ear/Nose/Throat Problems	<input type="checkbox"/>	<input type="checkbox"/>		Neurological Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>		Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Emotional Problems	<input type="checkbox"/>	<input type="checkbox"/>		Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrine/Hormone Problems	<input type="checkbox"/>	<input type="checkbox"/>		Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>		Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>		Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>		Urological Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal Problems	<input type="checkbox"/>	<input type="checkbox"/>		Viral Illness/Herpes	<input type="checkbox"/>	<input type="checkbox"/>	
Genital/Gynecological Problems	<input type="checkbox"/>	<input type="checkbox"/>		Other:	<input type="checkbox"/>	<input type="checkbox"/>	

EMOTIONAL/PSYCHIATRIC HISTORY

Prior Outpatient Treatment? Yes No If yes, please describe:

Reason	Dates Treated	By Whom

Prior Inpatient Treatment (for psychiatric, emotional, or substance abuse disorder)? Yes No If yes, please describe:

Reason	Date Hospitalized	Where

Family History (has anyone in your family ever been treated for any of the following)?

	Father	Mother	Aunt	Uncle	Brother	Sister	Children	Grandparent
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Panic Attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Post Traumatic Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Bipolar Disorder/Manic Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Alcohol Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Drug Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal

Suicide Attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Psychiatric Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal

Past Psychiatric Medications (if you have ever taken any of the following medications, indicate the date, dosage, and how helpful they were)

Antidepressants	Check if taken	When?	Dosage?	Did it help?	Any side effects?
Prozac (fluoxetine)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Zoloft (sertraline)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Luvox (fluvoxamine)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Paxil (paroxetine)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Celexa (citalopram)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Effexor (venlafaxine)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cymbalta (duloxetine)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wellbutrin (bupropion)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Remeron (mirtazapine)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Serzone (nefazodone)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anafranil (clomipramine)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pamelor (nortriptyline)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tofranil (imipramine)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Elavil (amitriptyline)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pristiq (desvenlafaxin)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Desyrel (trazadone)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Viiibryd (vilazodone)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Adapin (doxepin)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asendin (amoxapine)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ludomil (maprotiline)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Norpramin (desipramine)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Surmontil (trimipramine)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vivactil (protriptyline)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Antipsychotics/Mood Stabilizers	Check if taken	When?	Dosage?	Did it help?	Any side effects?
Seroquel (quetiapine)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Zyprexa (olanzapine)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Geodon (ziprasidone)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abilify (aripiprazole)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clozaril (clozapine)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Haldol (haloperidol)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prolixin (fluphenazine)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sedative/Hypnotics	Check if taken	When?	Dosage?	Did it help?	Any side effects?
Ambien (zolpidem)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sonata (zaleplon)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Restoril (temazepam)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rozerem (ramelteon)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Desyrel (trazodone)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

ADHD Medications	Check if taken	When?	Dosage?	Did it help?	Any side effects?
Adderall (amphetamine)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Concerta (methylphenidate)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ritalin (methylphenidate)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Strattera (atomoxetine)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Antianxiety Medications	Check if taken	When?	Dosage?	Did it help?	Any side effects?
Xanax (alprazolam)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ativan (lorazepam)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Klonopin (clonazepam)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Valium (diazepam)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tranxene (clorazepate)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Buspar (buspirone)	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other Medications (specify)	Check if taken	When?	Dosage?	Did it help?	Any side effects?
	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

SUBSTANCE USE HISTORY

Substance Use Status:

- No history of abuse Active abuse Early full remission Early partial remission Sustained full remission Sustained partial remission

Treatment History:

- Outpatient Inpatient 12-step program Stopped on own Other:

Substances Used (check all that apply)

Ever Used?	First use age	Last use age	Currently Used?	Frequency	Amount
<input type="checkbox"/> Alcohol			<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Amphetamines/Speed			<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Barbiturates			<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Caffeine			<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Cocaine			<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Crack Cocaine			<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Ecstasy			<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Hallucinogens (LSD)			<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Heroin			<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Inhalants			<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Marijuana			<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Methadone			<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Methamphetamine			<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Painkillers			<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Nicotine/Tobacco			<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> PCP			<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Tranquilizers			<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Other:			<input type="checkbox"/> Yes <input type="checkbox"/> No		

FAMILY HISTORY

Family of Origin

Present During Childhood	Present entire childhood	Present part of childhood	Not present at all	Parents' Current Marital Status:	Childhood Family Experience:
Biological Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Married to each other <input type="checkbox"/> Separated for ____ years <input type="checkbox"/> Divorced for ____ years <input type="checkbox"/> Mother remarried ____ times <input type="checkbox"/> Father remarried ____ times <input type="checkbox"/> Mother involved with someone <input type="checkbox"/> Father involved with someone <input type="checkbox"/> Mother deceased for ____ years Age of patient at mother's death: ____ <input type="checkbox"/> Father deceased for ____ years Age of patient at father's death: ____	<input type="checkbox"/> Outstanding home environment <input type="checkbox"/> Normal home environment <input type="checkbox"/> Chaotic home environment <input type="checkbox"/> Neglected <input type="checkbox"/> Witnessed physical/verbal/sexual abuse towards others <input type="checkbox"/> Experienced physical/verbal/sexual abuse from others Age of emancipation from home: _____
Biological Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Adoptive Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Adoptive Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Stepmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Stepfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Brother(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Sister(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

DEVELOPMENTAL HISTORY

Problems during mother's pregnancy	<input type="checkbox"/> None <input type="checkbox"/> High blood pressure <input type="checkbox"/> Kidney infection	<input type="checkbox"/> German measles <input type="checkbox"/> Emotional stress <input type="checkbox"/> Bleeding	<input type="checkbox"/> Alcohol use <input type="checkbox"/> Drug use <input type="checkbox"/> Cigarette use	<input type="checkbox"/> Other:
Birth	<input type="checkbox"/> Normal delivery <input type="checkbox"/> Difficult delivery <input type="checkbox"/> Cesarean delivery <input type="checkbox"/> Complications:			
Birth Weight	_____ lbs. _____ oz.			
Infancy	<input type="checkbox"/> Feeding problems <input type="checkbox"/> Sleep problems <input type="checkbox"/> Toilet training problems			

Delayed Development Milestones (check only those milestones that did not occur at an expected age)

- | | | | | |
|---|---|--|--|--|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Rolling over | <input type="checkbox"/> Standing | <input type="checkbox"/> Walking | <input type="checkbox"/> Feeding self |
| <input type="checkbox"/> Speaking words | <input type="checkbox"/> Speaking sentences | <input type="checkbox"/> Controlling bladder | <input type="checkbox"/> Controlling bowels | <input type="checkbox"/> Sleeping alone |
| <input type="checkbox"/> Dressing self | <input type="checkbox"/> Engaging peers | <input type="checkbox"/> Tolerating separation | <input type="checkbox"/> Playing cooperatively | <input type="checkbox"/> Riding tricycle |
| <input type="checkbox"/> Riding bicycle | <input type="checkbox"/> Other: | | | |

Childhood Health

- | | | | | |
|--|---|--|--|---|
| <input type="checkbox"/> Chickenpox (age:) | <input type="checkbox"/> German measles (age:) | <input type="checkbox"/> Red measles (age:) | <input type="checkbox"/> Rheumatic fever (age:) | <input type="checkbox"/> Whooping cough (age:) |
| <input type="checkbox"/> Scarlet fever (age:) | <input type="checkbox"/> Lead poisoning (age:) | <input type="checkbox"/> Mumps (age:) | <input type="checkbox"/> Diphtheria (age:) | <input type="checkbox"/> Poliomyelitis (age:) |
| <input type="checkbox"/> Pneumonia (age:) | <input type="checkbox"/> Tuberculosis (age:) | <input type="checkbox"/> Mental retardation | <input type="checkbox"/> Autism | <input type="checkbox"/> Ear infections |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies to: | | | |

Emotional/Behavioral Problems

- | | | | | |
|--|---|--|---|---|
| <input type="checkbox"/> Drug use | <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Chronic lying | <input type="checkbox"/> Stealing | <input type="checkbox"/> Violent temper |
| <input type="checkbox"/> Fire setting | <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Animal cruelty | <input type="checkbox"/> Assaults others | <input type="checkbox"/> Disobedient |
| <input type="checkbox"/> Repeats words of others | <input type="checkbox"/> Not trustworthy | <input type="checkbox"/> Hostile/angry mood | <input type="checkbox"/> Indecisive | <input type="checkbox"/> Immature |
| <input type="checkbox"/> Bizarre behavior | <input type="checkbox"/> Self-injurious threats | <input type="checkbox"/> Frequently tearful | <input type="checkbox"/> Frequently daydreams | <input type="checkbox"/> Lack of attachment |
| <input type="checkbox"/> Distrustful | <input type="checkbox"/> Extreme worrier | <input type="checkbox"/> Self-injurious acts | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Easily distracted |
| <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Often sad | <input type="checkbox"/> Breaks things | <input type="checkbox"/> Other: | |

Social Interaction

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Normal social interaction | <input type="checkbox"/> Isolates self | <input type="checkbox"/> Alienates self | <input type="checkbox"/> Inappropriate sex play |
| <input type="checkbox"/> Dominates others | <input type="checkbox"/> Very shy | <input type="checkbox"/> Associates with acting out peers | <input type="checkbox"/> Other: |

Intellectual/Academic Functioning

- | | | | | |
|--|--|---|--|---|
| <input type="checkbox"/> Normal intelligence | <input type="checkbox"/> High intelligence | <input type="checkbox"/> Learning problems | <input type="checkbox"/> Authority conflicts | <input type="checkbox"/> Attention problems |
| <input type="checkbox"/> Underachieving | <input type="checkbox"/> Mild retardation | <input type="checkbox"/> Moderate retardation | <input type="checkbox"/> Severe retardation | |

Current or highest education level:

SOCIO-ECONOMIC HISTORY

Living Situation: <input type="checkbox"/> housing adequate <input type="checkbox"/> homeless <input type="checkbox"/> housing overcrowded <input type="checkbox"/> dependent on others for housing <input type="checkbox"/> housing dangerous/deteriorating <input type="checkbox"/> living companions dysfunctional	Social Support System: <input type="checkbox"/> supportive network <input type="checkbox"/> few friends <input type="checkbox"/> substance-use-based friends <input type="checkbox"/> no friends <input type="checkbox"/> distance from family of origin	Financial Situation: <input type="checkbox"/> no current financial problems <input type="checkbox"/> large indebtedness <input type="checkbox"/> poverty or below-poverty income <input type="checkbox"/> impulsive spending <input type="checkbox"/> relationship conflicts over finances
Employment: <input type="checkbox"/> employed and satisfied <input type="checkbox"/> employed but dissatisfied <input type="checkbox"/> unemployed <input type="checkbox"/> coworker conflicts <input type="checkbox"/> supervisor conflicts <input type="checkbox"/> unstable work history <input type="checkbox"/> disabled:	Legal History: <input type="checkbox"/> no legal problems <input type="checkbox"/> now on parole/probation <input type="checkbox"/> arrest(s) not substance-related <input type="checkbox"/> arrest(s) substance related <input type="checkbox"/> court ordered this treatment <input type="checkbox"/> jail/prison _____ time(s) total time served:	Military History: <input type="checkbox"/> never in military <input type="checkbox"/> served in military – no incident <input type="checkbox"/> served in military – with incident <input type="checkbox"/> currently serving in military <input type="checkbox"/> honorable discharge <input type="checkbox"/> other type of discharge:
Sexual History: <input type="checkbox"/> straight/heterosexual orientation <input type="checkbox"/> lesbian/gay/homosexual orientation <input type="checkbox"/> bisexual orientation <input type="checkbox"/> transsexual <input type="checkbox"/> asexual <input type="checkbox"/> unsure/questioning orientation <input type="checkbox"/> currently sexually active <input type="checkbox"/> currently sexually satisfied <input type="checkbox"/> currently sexually dissatisfied <input type="checkbox"/> age first sex experience: ____ <input type="checkbox"/> age first pregnancy/fatherhood: ____ <input type="checkbox"/> history of promiscuity age ____ to ____ <input type="checkbox"/> history of unsafe sex age ____ to ____	Cultural/Spiritual/Recreational History Cultural Identity (ethnicity, religion): Describe any cultural issues that contribute to current problem(s): Currently active in community/recreational activities? <input type="checkbox"/> Yes <input type="checkbox"/> No Formerly active in community/recreational activities? <input type="checkbox"/> Yes <input type="checkbox"/> No Currently engage in hobbies? <input type="checkbox"/> Yes <input type="checkbox"/> No Currently participate in spiritual activities? <input type="checkbox"/> Yes <input type="checkbox"/> No Relationship History and Current Family: <input type="checkbox"/> married <input type="checkbox"/> children living at home <input type="checkbox"/> divorced <input type="checkbox"/> children living elsewhere <input type="checkbox"/> single <input type="checkbox"/> widowed <input type="checkbox"/> in a relationship	