Name (Please Print)**:**____ **Date:** ____________________

In order to best help you, we would like to know some things about you. If you have any questions about anything we've asked, please ask for assistance. <u>If you are uncomfortable providing answers to any of these questions, please draw a single line through the question and skip it.</u>

1. FAMILY AND SOCIAL LIFE

Living Situation			
Household Members (Name)	Relationship to Client	Age	Quality of Relationship
Significant Family Members/ Others not listed above	Relationship to Client	Age	Quality of Relationship

Family's Religious Preference: ❑Catholic ❑ Baptist ❑ Jewish ❑ Lutheran ❑ Methodist ❑ Muslim ❑ Pentecostal ❑ Presbyterian ❑ Other: ____________________________

Using the following scale, please rate each of the listed below. (For example, if you are having "minor difficulty," check the box before the "yes," and then write a "1" in the space:

1 **Minor difficulty**	**2** **More than a little difficulty**	**3** **Moderate difficulty**	**4** **Quite a bit of difficulty**	**5** **Serious Difficulty**

Are you having any difficulties or concerns about the place where you live? ❑ NO ❑ YES Rate: ______

Are you having any difficulties or concerns about how you get along with others? ❑NO ❑ YES Rate: ______

Are you having any difficulties with spiritual or religious matters? ❑NO ❑ YES Rate: ______

Do you have any sexual orientation issues or concerns? ❑NO ❑ YES Rate: ______

Are you having any difficulties or concerns about parenting your children? ❑NO ❑ YES Rate: ______

Are you having any difficulties relating to alcohol or other drug use (self or others)? ❑NO ❑ YES Rate: ______

Are you having any difficulties relating to any other addictive behaviors? ❑NO ❑ YES Rate: ______

2. BASIC NEEDS

Are you concerned about any basic needs such as food and clothing? ❑NO ❑ YES Rate: ______

Are you having any difficulties getting where you need to go (transportation)? ❑ NO ❑ YES Rate: ______

Are you having any difficulties regarding legal concerns? ❑NO ❑ YES Rate: ______

Name (Please Print)**:**____ **Date:** ________________

Education, Employment & Military Information

Education History (Check All That Apply): ❑GED ❑ HS Grad ❑ College: Number of Years
Degree/Major: _______________________ ❑ Other Degree: _______________________
Highest Grade Completed: ______________ Vocational Year Completed: ______________

History of Learning Difficulties
❑ None Reported
❑ Learning Disability - Type:
❑ Mental Retardation
❑ Special School Placement:
❑ Other: ____

Barriers to Learning
❑ None Reported
❑ Inability To Read or Write
❑ Other: ____

Special Communication Needs
❑ None Reported
❑ TDD/TTY Device
❑ Sign Language Interpreter
❑ Assistive Listening Device(s)
❑ Language Interpreter Services Needed - Other Spoken Language:
❑ Other: ____

If Employed, Name of Employer:

Job Performance History: Number Of Jobs In Last 5 Years - Comments:

Attendance: ❑ Above Average ❑ Normal ❑Tardiness ❑ Absenteeism
Performance: ❑ Above Average ❑ Good ❑ Average ❑ Below Average

Employment Interests/Skills:

Are you satisfied with your job? ❑No ❑ Yes
Are you experiencing financial problems? ❑No ❑ Yes
(If not currently employed) - Do you want to work? ❑No ❑ Yes
Are you concerned that employment will affect benefits? ❑No ❑ Yes

Comments on past or current skills/interests:

Military History:
❑ No ❑ Yes If yes, describe branch of service, any pertinent duties and any trauma experienced during service as applicable:
❑ National Guard/Reserves ❑ Army ❑ Navy ❑ Air Force ❑ Marines ❑ Coast Guard ❑ Other: ____________

Type of Discharge, if other than General/Honorable: ____

Date of Discharge and Rank at Discharge:____

Legal History

Legal Guardian /Custodian ❑ No ❑ Yes If yes, Name and Phone Number: ___________________________

3. HEALTH AND SAFETY

Medical History	
Primary Care Physician:	**Phone:**
Physician/Clinic Address:	**City:**
When did you last see your physician?	For what reason?
Are you currently pregnant/nursing? ❑YES ❑NO	

Name (Please Print)**:** ______________________ **Date:** ____________

3. HEALTH AND SAFETY (Continued)

SECTION I: Please check "yes" or "no" for each item: Have you ever had?	**YES**	**NO**
A disorder of eyes, ears, nose or throat?	❑	❑
Dizziness, fainting, headache, seizure, convulsions, paralysis, stroke, head trauma (with or without loss of consciousness) or other neurological disease?	❑	❑
Persistent coughing, bronchitis, asthma, emphysema, tuberculosis, or other disorder of your lungs?	❑	❑
Chest pain, high blood pressure, rheumatic fever, murmur, heart attack, other disorder of the heart/ blood vessels?	❑	❑
Intestinal bleeding, ulcer, hernia, colitis, other disorder of the stomach, intestines, liver (e.g. hepatitis) or gallbladder?	❑	❑
Disorder of kidney; bladder; prostate; reproductive system including HIV or other sexually transmitted diseases?	❑	❑
Diabetes, thyroid, or other endocrine disorders?	❑	❑
Arthritis or other disorder of the muscles or bones, including the spine, back or joints?	❑	❑
A tumor, cancer, or disorder of skin or lymph glands?	❑	❑
If sexually active, do you use a condom and/or a means of birth control?	❑	❑

If you are experiencing pain, please rate: **No Pain** ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 **Most Severe Pain Imaginable**

SECTION II: Medication allergies? ❑ NO ❑ YES If yes, indicate types below

Specify Types:

SECTION III: **Do the following occur frequently?**	**YES**	**NO**		**YES**	**NO**
Headaches	❑	❑	Frequent, difficult or painful urination	❑	❑
Hoarse throat	❑	❑	Menstrual pain	❑	❑
Ear infections/plugging/pain	❑	❑	Abdominal pain/flank pain	❑	❑
Fainting spells or balance problems	❑	❑	Nausea/vomiting	❑	❑
Breathing problems/cough	❑	❑	Easy bruising or unusual bleeding	❑	❑
Fevers	❑	❑	Joint/muscle pain	❑	❑
Chest pain	❑	❑			

Have you been treated for any of the conditions checked in Section I and II ❑ YES ❑ NO

Which conditions?	Who treated you?	When?

Do you have any disability restrictions because of these conditions? ❑ YES ❑ NO

Condition:	Restrictions:

Are you currently taking any prescribed Medication? (If yes, please list below) ❑ YES ❑ NO

Name of medication:	**Dose:**	**When taken:**	**For what:**	**Prescribed by?**	**Does the Medication Seem to be Working?**
					❑ Yes ❑ No
					❑ Yes ❑ No
					❑ Yes ❑ No
					❑ Yes ❑ No
					❑ Yes ❑ No

Name (Please Print)**:** ____ **Date:** ____________________

3. HEALTH AND SAFETY (Continued)

Past Psychotropic Medications ❑ None	
Psychotropic Medication	**Reason For Discontinuation**

Do you currently use (Check all that apply):

❑ Alcohol	❑ Tobacco	❑ Non-prescription drugs or herbal remedies
❑ Injected drugs	❑ Caffeine	

Contagious Illnesses:

As far as you are aware, do you currently have any contagious illnesses? ❑ Yes ❑ No

If yes, what symptoms?

Immunization Status: Are your immunizations up to date? ❑ Yes ❑ No

If not, what shots or immunizations are needed?

4. NUTRITIONAL INFORMATION

How many meals do you eat a day?

Give examples of what you would eat in a normal day [include snacks]:

Do you consider yourself to be: ❑ Underweight ❑ Overweight ❑ No	By how many pounds?

Are you on any special diet? ❑Yes ❑ No
Explain:

How has your weight changed in the past six [6] months?

Do you have problems with: ❑ Chewing ❑ Swallowing ❑ Choking ❑ Nausea
❑ Binge eating ❑ Purging (purposeful vomiting) ❑ None of these

Is there anything else about your medical history or health and safety issues that you would like to tell us about?

What prompted you to seek treatment at this time?

Is there any additional information you think might be helpful for the therapist to be aware of?

Signature of Person Completing Form: ____ **Date:** ____________________

(If person seeking services is not the same person who completed the form, please state relationship: ______________