Name: _____ Date: _____

Children/Siblings

	Name	Living arrangement	Occupation	Age
(1)				
(2)				
(3)				
(4)				

List other individuals residing in the home: _____

By whom were you referred? _____

Presenting problem(s): _____

_____

_____

Health Information

Appetite: ☐ Above Average ☐ Average ☐ Poor
Sleep difficulties ☐ Yes ☐ No
If yes, please describe: _____

Alcohol Use ☐ Current ☐ Past ☐ No history
# of drinks per week _____ Duration _____

Drug Use ☐ Current ☐ Past ☐ No history
If yes, please describe: _____

Allergies: _____
Present medical conditions: _____
Date of last physical: _____

Serious accidents, illnesses, or surgeries (please list, including dates): _____

_____

_____

Current Medications/Purpose: _____

_____

Personal Physicians(s): (1) _____ Phone _____
(2) _____ Phone _____

Previous Therapy/ Counseling: ☐ Yes ☐ No Dates _____
With whom? _____
Purpose of treatment: _____