**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date:\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_\_\_\_**

Reason(s) for seeking help at this time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your goal for today’s visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What have you already done to try to help? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a history of any of the following? (Please check all that apply)

|  |  |
| --- | --- |
| * ADHD * Learning Problems * Anxiety * Panic Disorder * Depression * Bipolar Disorder * Chronic Pain | * Eating Disorder * Autism Spectrum Disorder * Schizophrenia * Substance Abuse * Suicide Attempt * Trauma * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Is there a **family history** of any of the following? (Please check all that apply and indicate who in your family has each issue)

|  |  |
| --- | --- |
| * ADHD \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Learning Problems \_\_\_\_\_\_\_\_\_\_\_ * Anxiety \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Panic Disorder \_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Depression \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Bipolar Disorder \_\_\_\_\_\_\_\_\_\_\_\_\_ * Chronic Pain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Eating Disorder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Autism Spectrum Disorder\_\_\_\_\_\_\_\_\_\_\_ * Schizophrenia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Substance Abuse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Suicide Attempt \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Trauma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_ |

# Hrs of sleep per night, on average? \_\_\_\_\_\_ Difficulty falling /staying asleep?  No  Yes

On average how many days per week do you drink alcohol? \_\_\_\_\_\_\_\_\_\_\_\_

On a typical day when you drink, how many drinks do you have? (one drink = 1 shot liquor, 1 beer, 1 glass of wine)

* I don’t drink alcohol
* less than one drink per day
* 1-2 drinks per day
* 3-4 drinks per day
* more than 5 drinks per day

In the past year have you used prescription or other drugs more than you meant to?  No  Yes

**List other drugs you currently use or have used in the past (indicate with check** ✓):

|  |  |  |  |
| --- | --- | --- | --- |
| **Substance** | **Never Used** | **Past use**  **(1+ yrs ago)** | **Current use** |
| **Cannabis** (marijuana, dabs, butane hash oil, etc.) |  |  |  |
| **Cocaine** (coke, crack, etc.) |  |  |  |
| **Prescription stimulants** (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.) |  |  |  |
| **Methamphetamine** (speed, crystal meth, etc.) |  |  |  |
| **Inhalants** (nitrous oxide, glue, gas, paint thinner, etc.) |  |  |  |
| **Sedatives or sleeping pills** (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHB, etc.) |  |  |  |
| **Hallucinogens** (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.) |  |  |  |
| **Opioids** (street: heroin, opium, etc. or prescription (non-medical use): fentanyl, oxycodone, hydrocodone, methadone, buprenorphine, etc.) |  |  |  |
| Other – specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |

Have you ever had psychotherapy?  No  Yes

If Yes (Please list provider(s) and dates, if known) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was helpful/not helpful about your past therapy experience?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever taken psychiatric medications?  No  Yes

If Yes (Please list types, dosage and dates, if known) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been psychiatrically hospitalized?  No  Yes

If Yes (Please list location(s) and dates) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a Psychiatric Advance Directive? (This is a document that expresses your wishes in the event that you are having a mental health crisis or need to be psychiatrically hospitalized.)

* No
* Yes (Please bring a copy so we can scan it into your chart)
* Unsure or would like more information about this

Do you have any guns or weapons in your home?

* No  Yes (How are they locked or secured?)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your strengths and hobbies/interests?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_