



**PRESENTING ISSUES**

Why are you seeking treatment?

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What do you hope to gain from therapy?

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What are your interests and activities? How do you cope with stress?

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Do you feel like you're having significant relationship problems with family, friends and/or colleagues? Please explain if you wish.

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Do you have any problems with appetite or eating habits? Please explain if you wish.

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Do you have any problems with sleeping (nightmares, insomnia, night terrors, sleeping too much, teeth grinding, snoring)? Please explain if you wish.

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Do you or others think you have a substance use problem? Please explain if you wish.

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Do you have a significant legal history or court involvement? Please explain if you wish.

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**PAST MEDICAL HISTORY**

Who is your primary care physician?

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When was your most recent physical?

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Please explain any significant concerns or findings.

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List any significant medical history such as serious accidents, hospitalizations, surgeries seizures, head injuries, high blood pressure, and chronic medical conditions:

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List *all* mental health and/or medical medications you take or have taken in the last year – prescribed, over-the-counter vitamins, herbs and others.

Medication/drug	Dose (how much)?	Taken for	Prescribed and supervised by

Have you ever received psychological, psychiatric, drug or alcohol treatment before? If yes, please indicate.

When?	From whom?	For what?	With what results?

Have you ever taken medications for psychiatric or emotional problems? If yes, please indicate.

When?	Which medications?	From whom?	For what?	With what results?

In the table below, put a check in the box that indicates which illness or problem pertains to brothers, sisters, parents or other family members.

<i>ILLNESS OR PROBLEM</i>	<i>BROTHERS &amp; SISTERS</i>	<i>PARENTS</i>		<i>OTHER FAMILY MEMBERS (specify)</i>
		<i>Mother</i>	<i>Father</i>	
Language, needed speech therapy				
Learning, needed help in school				
Mental retardation				
Attention Deficit Hyperactivity Disorder (ADHD)				
Behavior Problems				
Autism/Pervasive Development Disorder (PDD)				
Seizures				
Muscular Dystrophy, Motor Diseases, Cerebral Palsy				
Depression, Manic-Depression, Schizophrenia, Nerves, Panic Attacks, Anxiety				
Physical or Sexual Abuse				
Alcoholism, Drug Use				
Deafness				
Blindness				
Asthma, Lung Problems, Heart Problems, Stomach or Intestine Problems, Kidney Problems				
Condition Similar to You (Please indicate)				