DOB: ________________

Medical Section

List any previous psychiatric (or alcohol and/or drug treatment) hospitalizations:

Reason for Treatment	Hospital/Place	Treatment Date	Length of Treatment

List any medical or surgical (operations) hospitalizations:

Reason for Treatment	Hospital/Place	Treatment Date	Length of Treatment

Please check the following illness(es) or conditions you have been treated for by a physician:

_____Anemia
_____Arthritis
_____Asthma
_____rectal bleed
_____cancer
_____diabetes
_____Emphysema
_____Seizures
_____headaches
_____gastritis
_____Glaucoma
_____heart attack
_____heart disease
_____hearing loss

_____ Hemorrhoids
_____ Hernia – type ________________
_____ High blood pressure
_____ Kidney problems
_____ Liver disease
_____ Pancreatitis
_____ Prostate problems
_____ Skin problems
_____ Thyroid disorder
_____ Tuberculosis (TB)
_____ Ulcers
_____ Head Injury/hx of concussion
_____ Weight change

What medications are you taking, how much, and how often?

Name	How much/often?	Name	How much/often?

Height: _______________________ **Current Weight:** ________________

Are you allergic to any medications? ______ **YES** _____ **NO**

If "YES" list the medicine name (type) and the reaction that you had:

Name (type)	Reaction	Name (type)	Reaction

Health habits (Check all that apply):

_____ **Do you drink beer, wine, whiskey, or spirits?**

_____ **Have you ever felt that you should cut down on your drinking?**

_____ **Have people annoyed you by criticizing your drinking?**

_____ **Have you ever felt bad or guilty about your drinking?**

_____ **Have you ever had a drink in the morning to steady your nerves or to get rid of a hangover?**

_____ **Have you ever had a ticket while intoxicated? If "yes", how many times?**

Times? ______________ **When?** _____________

How frequently do you drink?

_____ **Daily** _____ **Twice/week** _____ **Monthly** _____ **Other:** _______________

Do you now, or have you in the past, used marijuana or any other street drug? _____ **YES** _____ **NO**

If "yes", what? ______________________ **How often?** ___________ **How long?** __________

Do you use tobacco? _____ **YES** _____ **NO** **If "yes", what, how long, and how much?**

Cigarettes/day __________ **Pipe/day** ___________

Cigars/day _____________ **Chew/dip** __________

What is the total number of years you have smoked/chewed? _____________________

GENETIC SECTION

Please list any biological children of the patient:

First Name	Age	Sex (M,F)	Any health problems (Yes/No)? When?

Have any members of your biological family had mental problems or received mental health or alcohol and drug treatment?

_____ **YES** _____ **NO**

If "yes", please describe the symptoms each individual experienced and was treatment helpful:

Relation/Name	Symptoms	Treatment Helpful (Yes/No)

Work Section

Current income situation:

_____ **Presently employed full time – Occupation** ____

Where: ____________________________________ **How long:** _______________________

_____ **Presently employed part time – Occupation** ____

Where: ____________________________________ **How long:** _______________________

_____ **Unemployed – How long:** ________________________ **Why:** ___________________________

_____ **Retired – When** ________________________________

_____ **Disabled (cannot work)** **Type of disability** ____

______ **Student – What grade/level** _______________________