

Who referred you to our office? _____

Have you ever had treatment for a mental or nervous condition before? Yes No

Where were you treated before? _____

Has anyone in your family ever been treated for a mental or nervous condition before? Yes No

Mother Father Brother/Sister Children Grandparents Other

Are you allergic to any medications or ever had an adverse reaction to any medications? Yes No

Please list drug allergies _____

Do you smoke? Yes No (How many packs per day? _____)

Do you drink alcohol? Yes No (How many alcoholic drinks do you consume per week? _____)

Are you involved in an investigation by the Department of Family/Children Services? Yes No

Are you involved in any legal actions or lawsuits? Yes No

Attorney's Name: _____ Type of Suit _____
(Divorce, Disability, Motor Vehicle Accident, Workers Comp, Other)

Are you involved in a worker's compensation claim? Yes No

What is your main complaint? _____

How long has this been occurring? _____

List any Medical Condition you are being treated for _____

Are you experiencing any of the following:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Depressed Mood | <input type="checkbox"/> Relationship/Family Problems | <input type="checkbox"/> General Stress | <input type="checkbox"/> Anxiety or Worry |
| <input type="checkbox"/> Problems at work | <input type="checkbox"/> Physical Health Problems | <input type="checkbox"/> Grief or Loss | <input type="checkbox"/> Substance Abuse Problems |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Inability to Sleep | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> No Interest in Things |
| <input type="checkbox"/> Problems at School | <input type="checkbox"/> Problems with Peers | | |

Patient Signature: _____

Date: _____

To protect identity theft, we require government issued photo identification upon check-in.