Name ____ Date of Birth: _____________________Today's Date: ____________

To assist me to better understand you, please answer the following questions to the best of your ability. If you need more room, please feel free to write on the back of this form. The information is confidential within the scope or Oregon law.

What brings you here today and what are your goals for treatment?

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MEDICAL HISTORY

1. Have you ever seen another therapist/counselor or received treatment for mental health or substance abuse problems?

no yes: Names and dates of previous or current mental health/chemical dependency treatment: _________________________

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Past or current mental health Challenges:

Depression	Post Traumatic Stress
Anxiety	Panic Attack (intense fear)
Anger Problem	Memory problems
Hallucinations	Phobias
Obsessive/Compulsive	Paranoia
Mood Swings	Sleeping 4 or less hour's night & feeling rested
Self harm	Suicidal Thoughts
Harming others	Homicidal Thoughts
Addictions	ADHD

2. Name of your primary physician/health care provider: ____

Date of most recent visit:____

3.. Please list any operations and/or hospitalizations (including dates): ____

____

4. What significant illnesses have you had, past and present? ____

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5. **List the names and amounts of any prescribed medications** :

Medication	Dose	Start date	Discontinued or current	Prescriber

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6. **List the over the counter, vitamins and/or herbal medications that you take**:

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7. Do you smoke/chew tobacco? no yes: How much? ______________________________________

8. How much coffee, tea, and caffeinated soda do you drink daily? _________________________

9. Do you have allergies (including medications)? no yes: Please list: ______________________

10. Have you ever had a head injury or seizure? no yes: Please describe: ______________________

11. Have you ever suffered from dizzy spells? no yes: Please describe: ________________________

12. Do you have any history or/current sleep problems? no yes: Please describe: ________________

13. Do you suffer from pain? no yes: Pain location: ______________ Pain intensity (1=mild, 10-extreme): ________ All the time? no yes: Some of the time? no yes: when/how long? ________________

Please circle items that apply to you:

14. Have you lost or gained any weight in the past 6 months? Estimate amount: +/- _______ no yes

15. Have you ever had any sexual problems? no yes: If comfortable, please describe: ______________

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16. Have you had any history of physical or sexual abuse? no yes: If comfortable, please list ages and brief description.

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17. History of violent behaviors towards yourself or others. no yes If yes please explain:______________

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SUBSTANCE USE HISTORY

1. Do you drink alcohol? no yes
2. Do you take drugs recreationally (prescription or non)? no yes

   If yes list drugs of choice:____
3. At what age did you start to drink/use drugs? _______ What is/was your preferred drink/drug? ______________
4. What is/was your average daily consumption during the past year? _______ now?________

5. When and what was your last drink or use of drugs? ______________________________
6. Have you ever thought that you have/had lost control of your drinking/using? no yes: When did you first realize this?

____

7. Have you ever tried to control or quit your drinking/use of drugs? no yes: Please describe: ____________

Were you successful? no yes: For how long? ______________________________

8. IV drug use now or in past? ? no yes: Drug used ______________________________

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SOCIAL HISTORY

1. Where were you born? ________________ Where were you raised? ________________
2. Ethnicity__________ Any specific ethnic or cultural traditions? Describe: ________________

____

3. What is the highest level of education you have completed? ____________ Where? ____________

____

Childhood Family History	Name	Current Age or age at death	Alive or Deceased	State of Health/Cause of Death Include mental health/substance use
Mother (biological/adoptive			A D	
(step)			A D	
Father (biological/adoptive)			A D	
(step)			A D	
Grandparent/Other			A D	
Siblings (circle one) b = biological, s = step a = adoptive/foster				
b s a			A D	
b s a			A D	
b s a			A D	
b s a			A D	
b s a			A D	
b s a			A D	
b s a			A D	

(if more family members please list on next page)

4. Do or did you, or any of your blood relatives have:

Thyroid conditions? self others: details: ______________________________

Diabetes? self others: details: ______________________________

High blood pressure? self others: details: ______________________________

Stroke? self others: details: ______________________________

Cancer? self others: details: ______________________________

Liver/Kidney Problems? self others: details: ______________________________

Heart or Lung Problems self others: details: ______________________________

Learning/Attention/
Hyperactivity Problems? self others: details: ______________________________

Eating Disorders? self others: details: ______________________________

Gambling/Compulsions? self others: details: ______________________________

Depression self others: details: ______________________________

Anxiety self others: details: ______________________________

Mental Illness/Psychosis? self others: details: ______________________________

Computer addiction self others: details: ______________________________

Sex Addiction self others: details: ______________________________

Spending Addiction self others: details: ______________________________

5. Is there any additional family history of alcoholism/chemical dependency or mental health problems? no yes:
Relationship(s) to you? ______________________ Details: ______________________________

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Any additional Health Related information: ______________________________

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Current Family History	Name	Current Age or age at death	Alive or Deceased	State of Health/Cause of Death Include mental health/substance use history
Spouse/Partner			A D	
Previous Spouse/Partner			A D	
Previous Spouse/Partner			A D	
Children: (circle one) b = biological, s = step a = adoptive/foster				
b s a			A D	
b s a			A D	
b s a			A D	
b s a			A D	
b s a			A D	
b s a			A D	

1. Are you currently married/partnered? no yes: How long? __________ Are you separated? yes no
2. If any previous marriage or partnerships, how many times married/partnered? ______________________________
3. At present, who lives with you? ______________________________
4. Are you currently employed? no yes: Where/how long______________________________

   Household income: ____________________
5. Previous Occupation ____________________
6. Do you have any current problems at work? no yes: Please describe: ______________________________
7. Are you presently in school? no yes: Where? ______________________________
8. Do you have spiritual beliefs? no yes: If comfortable, please describe ______________________________
9. Are you active in your church/religious/spiritual organization? no yes: Please list ______________________________

10. Please list any cultural beliefs or influences.

____

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11. In what other organizations/ activities are you involved? ________________________________

____

11. What do you do for fun/leisure activities? ______________________________________

____

12. Has there been a change in any of the above stated activities? no yes Please describe: ______________

____

13. Have you ever been charged with a legal offense? no yes: Please list ages and brief description: __________

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14. Have you ever been in the military? no yes: Please list branch, dates and type of discharge: ____________

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15. Any additional information you believe might be beneficial to our work together: ____________________

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Thank you.