Personal and Health Information

Child's Name: _____ Date of Birth: _____

Street, City, ZIP: _____ SS#: _____

Family Information (check each method of contact that can be used):

Mother: _____ Phone: _____ ( )

Date of Birth: _____ Social Security Number: _____

Employer: _____ Phone: _____ ( )

Email Mother: _____ ( ) Father: _____ ( )

Father: _____ Phone: _____ ( )

Date of Birth: _____ Social Security Number: _____

Employer: _____ Phone: _____ ( )

Name and ages of others who reside with you:

Emergency contact person: _____

Relationship to you:_____ Phone: _____

Have you ever consulted a mental health professional?

If so, whom and when: _____

Medical: Specify medication and dosages currently taken:

Your physician: _____ Phone:_____

Last physical exam date: _____ Height: _____ Weight: _____

If a professional referred you, may we send them a confirmation of your appointment? If yes, Provider name and location:

Circle any condition you have ever been treated for OR have indications of:

1. High blood pressure, anemia, hypoglycemia, diabetes, any blood disorder
2. Epilepsy, memory loss, migraine headaches, paralysis, any brain disorder

Please list any other relevant medical condition not already indicated:

Circle any **recent changes** (last six months) in your:

1. Vision, hearing, coordination, balance, strength, speech, memory
2. Energy, sleeping, eating, elimination, menstrual cycle, sexual activity

Check all that apply:

	Current	Past		Current	Past
Appetite change	_____	_____	Eating disorder	_____	_____
Weight Loss	_____	_____	Weight Gain	_____	_____
Difficulty concentrating	_____	_____	Confusion	_____	_____
Memory Loss	_____	_____	Seizures	_____	_____
Head Injury	_____	_____	Chronic Pain	_____	_____
Anxiety	_____	_____	Depressed mood	_____	_____
Irritability	_____	_____	Mood Swings	_____	_____
Excessive worrying	_____	_____	Withdrawal	_____	_____
Arguments	_____	_____	Anger	_____	_____
Physical Abuse	_____	_____	Sexual Abuse	_____	_____
Sexual Problems	_____	_____	Sexual functioning	_____	_____
Suicidal Thoughts	_____	_____	Suicidal actions	_____	_____
Thoughts to harm others	_____	_____	Harm toward others	_____	_____
Suffered from trauma	_____	_____	Sleep problems	_____	_____

This section relates to behaviors associated with possible addiction issues:

	Current	Past		Current	Past
Alcohol consumption	_____	_____	Alcohol Abuse	_____	_____
Abuse of illicit drugs	_____	_____	Abuse of prescriptions	_____	_____
Blackouts	_____	_____	Consequences from A/D	_____	_____
DUI or PD Charge	_____	_____	Arrested for Drugs	_____	_____
Tobacco Use	_____	_____	Food misuse	_____	_____
Sexual	_____	_____	Pornography	_____	_____

Do you have any special needs or concerns (e.g., language barriers, disabilities):

Briefly describe in reasons for seeking help at this time:

Signature _____ Date _____