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?

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: ________________

Past or current mental health Challenges:

Depression	Post Traumatic Stress
Anxiety	Panic Attack (intense fear)
Anger Problem	Avoidance of going places due to fear
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? ________________________________

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

Medication Dose Start date Discontinued or current Prescriber

____
____
____
____
____
____
____
____

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

____
____
____
____

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? yes no: 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: ______________________________

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

____
____

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

____
____

SUBSTANCE USE HISTORY

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

If yes list drugs of choice:______________________________

2. At what age did you start to drink/use drugs?______________What is/was your preferred drink/drug? ______________________________

3. What is/was your average daily consumption in a week?______________________________

4. When and what was your last drink or use of drugs? ______________________________

5. Have you ever thought that you have/had lost control of your drinking/using? no yes: When did you first realize this?

____

6. 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? ______________________________

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

____

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 Use concerns ☐ 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: ______

   ______

   Any additional Health Related information: ______

   ______

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.

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

12. What do you do for fun/leisure activities?

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

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

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

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

Thank you.