Today's Date: ____________________

Patient Name: ____
(Last) *(First)* *(Middle Initial)*

Phone: *Home*: ____________________ *Work:* ____________________ *Cell:* ________________________

Referred by: ____

Primary Care Physician: ____

Address: ____

Phone: ___________________________ Fax: ___________________________

Current Medical Problems/Medications:

____
____
____
____

Psychiatric Medications you are currently taking:

____
____
____
____

Prescribed by:

____
____
____

Medications you have taken in the past:

____
____
____
____

Drug/Other allergies or adverse reactions:

____

____

____

Are you employed outside of the home? _____*Yes* _____*No* *Occupation:* ________________________

Current Concerns/Problem Areas:

____

____

____

____

____

Current/Previous Mental Health Treatment/Hospitalizations:

____

____

____

____

____

Substance Use History:

Do you think you have a problem with alcohol or drugs? _____*Yes* _____*No*

Does anyone in your family have a history of problems with:

Alcohol: _____*Yes* _____*No* Drugs: _____*Yes* _____*No*

*If yes, who?*____

Have you ever had inpatient treatment for drug or alcohol problems: _____*Yes* _____*No*

Have you ever had outpatient treatment for drug or alcohol problems: _____*Yes* _____*No*

What do you hope to get from meeting with me?

____

____

____

____

____

____

____

<u>EMERGENCY CONTACT PERSON / RELATIONSHIP</u>:

Name: ________________________________ Relationship: ___________________________

Address: ____

Phone #s: Work: ___________________________ Home: _______________________________

_____________________________________ _______________

(Patient Signature) *(Date)*