NAME:____ **DATE:** ____________
(Last) (First) (Middle)

How were you referred for this evaluation? ______________________________
In a few words, what is your main problem currently? ______________________________
____

Marriage/Committed Relationship: Spouse's/Partner's name:______________________ Age: _______
Occupation: ______________ Length of marriage/relationship : ________ Prior Relationships?________
If not married/partnered, do you have a current romantic involvement? ____________ Length: __________

CHILDREN: (Please circle their name if they are stepchildren)

First Name	Age	Sex	School Adjustment	Health Problems

Please briefly describe your relationships with your children: ______________________________
____

OCCUPATION:______________________________ Time on current job: ____________

FAMILY BACKGROUND:
Where did you grow up? ______________________________
Who raised you? ______________________________ Are you adopted? ______________
Parents were: ___ never married ___ married ___separated ____divorced ___widowed
Please list family members that have suffered from chemical dependency or emotional problems: ______________
____
Father's Age: ___ Occupation: ______________ Mother's Age: ____ Occupation: ______________
Stepfather's age: ___Occupation: ______________ Stepmother's Age:___ Occupation: ______________
Please briefly describe your relationships with your parents: ______________________________
____

Brothers	Age	Sisters	Age

Briefly describe your relationships with your brothers and sisters: ______________________________
____

CHILDHOOD HISTORY: As a child, did you have frequent problems with the following: (put ages next to all that apply)

Speech impediments	_____	Temper tantrums or much anger	____	Bad headaches	____
Unreasonable fears	_____	Physical fights with others	____	Tension/nerves	____
Getting in trouble	_____	Problems with parents/teachers	____	Severe beatings or abuse	____
Lots of crying	_____	Sexual molestation/abuse	____	Nightmares	____
Bedwetting	_____	Hyperactivity/attention-deficit	____	Stealing	____

As a teenager, list any big problems you had: ______________________________
____

EDUCATION:
What was the highest level of education you completed: ______________ Usual grades were: ________
If you did not obtain a high school diploma, did you get your GED? ______________
Did you ever drop out of school or were you ever suspended or expelled?______________
Were you ever held back a grade or did you ever receive special education?______________

RELIGION: Religious upbringing: ________________________ Any preference of attendance now? ________________

LEGAL: Have you had any legal or court involvement? ______________________________________

FINANCIAL: Please describe any financial difficulties: ____

PERSONAL: Have you had any long-standing problems with:

Stubbornness	____	Shyness	____	Much boredom	____	Insecurity	____
Stealing	____	Moodiness	____	Low self-confidence	____	Putting things off	____
Depression	____	Tension	____	Jealousy	____		

Have you ever thought about or attempted suicide? ______ If yes, explain: ____
____

PSYCHOLOGICAL ASSISTANCE: Have you ever had psychiatric or psychological assistance before? (Please give approximate date, places, and reasons for assistance)

____
____

Have you ever had chemical dependency treatment? ____

PHYSICAL HEALTH HISTORY:

Personal physician: ____ Date of last examination: _________________________
Current medications: ____
Name any medication allergies: ____
Present health problems: ____
Past health problems: ____
Do you use over-the-counter medications (ex. diet pills, stimulants, diuretics, laxatives, sleep aids)? _________________________
____
Have you ever had a head injury with loss of consciousness?____
Have you ever suffered seizures, fits, or convulsions?____

LIFESTYLE/HABITS:

How much do you drink daily of the following? (indicate, for example, 6 cups, 2 glasses, 4 cans, etc.)
Coffee _____________ Tea _____________ Caffeinated soft drinks _______________
How much, if any, do you spend in an average month on gambling? ____
How much tobacco do you use daily? ____
Do you think you have a problem with eating patterns? ____________ Sex drive? ____________ Sleep? __________________
What are your recreational activities/hobbies?____
How much alcohol, if any, do you drink (approximate frequency and amount)?____
Have you ever used street drugs?_________________

ADULTS:

Have you ever felt you ought to cut down on your alcohol drinking or drug use? ______ yes ______ no
Have you had people annoy you by criticizing your drinking or drug use? ______ yes ______ no
Have you ever felt bad or guilty about your drinking or drug use?______ yes ______ no
Have you ever had a drink or used drugs as an eye opener first thing in the morning to steady your nerves or get rid of a hangover, or to get the day started? ______ yes ______ no

ADOLESCENTS 12-18:

Have you used more than one chemical at the same time in order to get high? ______ yes ______ no
Do you avoid family activities so you can use? ______ yes ______ no
Do you have a group of friends who also use? ______ yes ______ no
Do you use to improve your emotions, such as when you feel sad or depressed? ______ yes ______ no