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