

What was the highest grade you completed in school? _____

2. FAMILY HISTORY:

Mother

Father

Health

Deceased, poor,
good, fair,
excellent

Deceased, poor,
good, fair,
excellent

Personality _____

Special Problems _____

If dead, cause of
death (age and
date of death) _____

Current marital
status of parents

Married, separated,
divorced, widowed.

Married, separated,
divorced, widowed.

Your past
relationship

Poor, fair, good,
excellent, other_____

Any Daughter Poor, fair, good
excellent, other_____

Parents'
relationship

Poor, fair, good, excellent, other _____

Give similar information regarding step-parents or other persons who were responsible for your upbringing. _____

A. How would you describe your mother? (List five adjectives)

B. How would you describe your father? (List five adjectives)

3. SIBLINGS (Brothers and Sisters) Include full siblings, half-siblings, step-siblings and adopted siblings.

Name

Sex

Age

Residence

Health

Social Problems

4. MILITARY HISTORY (if applicable)

Branch _____

Dates 19____ to 19____

Nature of Discharge _____

Special Problems _____

5. MARRIAGES

Number of marriages 0 1 2 3 4 5

<u>Spouses Names</u>	<u>Dates</u>	<u>Reason for Termination of Relationship</u>
_____	19____ to 19____	_____
_____	19____ to 19____	_____
_____	19____ to 19____	_____
_____	19____ to 19____	_____
_____	19____ to 19____	_____

6. CHILDREN (By all marriages)

<u>Name</u>	<u>Age</u>	<u>Sex</u>	<u>Legal Status:</u> <u>Own, adopted,</u> <u>stepchild, other</u>	<u>Residence</u>	<u>Marital Status</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

7A.

LIST ALL DOCTORS YOU HAVE SEEN IN THE LAST FIVE YEARS:

<u>Name</u>	<u>Specialty</u>	<u>Phone#</u>	<u>When first seen/last seen</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

B. List all present medical problems

8. If you are taking medication for any of these problems please list all the medications, dosage, and frequency.

9. Please list with dates any serious illnesses, operations, or injuries you have had.

Operation, Illness, or Injury	Date and Physician Name

10. What is your height: _____ What is your weight? _____

11. Check one: Right Handed ___ Left Handed ___

12. Do you smoke? _____ No _____ Yes
If yes, how much? _____

13. Do you drink tea and/or coffee? _____ No _____ Yes
If yes, how many cups per day? _____

14. What are your hobbies and interests? _____

a. How many times a week do you engage in an athletic event or game (tennis, jogging, baseball, etc)?

_____ None or If yes: _____ times a week

b. How many days a week do you spend time working on a hobby?

_____ None or If yes: _____ days a week

c. How many times a week do you attend a social events (party, club, etc.)? _____

or 4-6 wine glasses

_____ 2 fifth

_____ 1 water glass or 1 or 2
wine glasses

19. Did you drink whiskey, gin, vodka, or other hard liquor during the past month?

-----No (Go on to the next question)

_____ Yes

If Yes: About how often did you drink any hard liquor?

_____ Constantly _____ 1-2 days a week

_____ Every day _____ Weekends only

_____ Nearly every day _____ Less than weekly

_____ 3-4 days a week

About how much did you drink in a typical day?

(Note: 1 pint- 16 oz. or sixteen 1 oz. shots. There are 2 pints in 1 quart and a little over 1 ½ pints in a fifth).

_____ 4 pints or more _____ 2 pints

_____ 11-14 shots _____ 1 pint

_____ 7-10 shots _____ 4-6 shots

_____ 3 pints _____ 1-3 shots

20. How old were you the first time any of the following problems occurred because of alcohol?

a. Were fired because of drinking.

_____ Never or I was _____ years old

How many times did this happen? _____

b. Were picked up for drunk driving.

_____ Never or I was _____ years old

How many times did this happen? _____

c. Were you separated or divorced from spouse because of your drinking problem.

_____ Never or I was _____ years old

How many times did this happen? _____

d. Had to go to the hospital because of drinking.

_____ Never or I was _____ years old

How many times did this happen? _____

e. A doctor told you alcohol had harmed your health.

_____ Never or I was _____ years old.

How many times did this happen?_____

f. The first time you seriously tried to stop drinking.

_____Never or _____I was_____years old.

How many times did this happen?_____

21. How many times in your life do you estimate that you have taken the following substances?

Marijuana (including Hashish and THC)?

_____Never or _____Times _____Last Used?

Hallucinogens (LSD, Mescaline, Peyote, PCP, STP, Psilocybin, etc.)?

_____Never or _____Times _____Last Used?

Barbiturates and downers that weren't prescribed for your use?

_____Never or _____Times _____Last Used?

Oral Amphetamines, Ritalin, Methamphetamine, ("Speed, Meth, Crystal'), Diet Pills, and Other Amphetamines that weren't prescribed for your use?

_____Never or _____Times _____Last Used?

Opiates (Heroin, Vicoden, Etc. that weren't prescribed for your use?)

_____Never or _____Times _____Last Used?

Solvents (Glue, Aerosols, Toluene, Gasoline, Paint, Etc.)?

_____Never or _____Times _____Last Used?

Cocaine?

_____Never or _____Times _____Last Used?

Club Drugs (Ecstasy, MDMA, GHB, Rohypnol, Ketamine, Etc.)

_____Never or _____Times _____Last Used?

Are there any others? If Yes, which ones?

b. Have you ever had any of the following problems because of drug use?

___No ___Yes Marital separation or divorce because of your drug use?

___No ___Yes Laid off from work or fired because of your drug use?

___No ___Yes One or more arrests because of your drug use?

___No ___Yes A doctor has said that drugs have harmed your health?

___No ___Yes Used drugs intravenously?

22. Were you ever treated by a mental health worker such as a psychiatrist, psychologist, marriage family counselor, social worker (Check all that apply)

No, Never Treated Yes, Marriage Family Counselor
 Yes, Social Worker Yes, Other
 Yes, Psychiatrist Please specify _____
 Yes, Psychologist
 If Yes, why did you see them? _____

b. Did you ever attempt suicide?
 No or If Yes: _____ Actual number of times

If yes, how old were you the first time?

c. Did you ever feel as if your mind was being manipulated or actually controlled by some unusual or mysterious force?
 No Yes
 Please describe: _____

d. Have you ever felt influenced in unusual ways, such as by machines, hypnosis, radar waves, radio, television or newspapers?
 No Yes
 Please describe: _____

e. Have any of your close relatives ever seen a psychiatrist, psychologist, or other mental health worker for treatment of a nervous or emotional problem?
 No Yes

If Yes, fill out the answers for each of your relatives who have seen a psychiatrist, psychologist, or other mental health worker for treatment of nervous or emotional problem.

	<u>No</u>	<u>Yes</u>	<u>How Old</u> <u>First Time</u>	<u>How Old</u> <u>Now</u>	<u>What Were Their</u> <u>Symptoms</u>
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Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Any Brother	_____	_____	_____	_____	_____
Any Sister	_____	_____	_____	_____	_____
Any Son	_____	_____	_____	_____	_____
Any Daughter	_____	_____	_____	_____	_____

NOTE: If more than one brother, sister or child saw a mental health worker, please give information on each.

23. Have you ever spent the night in jail?

____ No ____ Yes If Yes, Why? _____

24. Have you ever hurt anyone in a fight badly enough so that they needed to see a doctor?

____ No ____ Yes If "Yes" explain? _____

25. Please list in detail your major concerns these days (for example, physical pain, arguing with spouse, money problems, etc.)

- A.
- B.
- C.
- D.

26. How do you spend your day? Please list all the activities you pursue. *(Be Specific and detailed)* Use the times of day listed as a guide.

What time do you generally wake up?

early morning...

mid morning...

late morning...

noon hour...

early afternoon...

mid afternoon...

late afternoon...

early evening...

middle evening...

late evening...

What time do you usually go to bed?

How do you spend the weekends? (Be Specific) _____

Which of the following have ever applied during your years in school?

	<u>Grade</u>		<u>Grade</u>
Afraid to attend	_____	Picked on	_____
Problems with teachers	_____	Fights	_____
Frequent or prolonged absence	_____	Enjoyed school	_____
Disciplined by school personnel	_____	Failing Grades	_____
Expulsions/suspensions	_____	Honor role	_____
Medical problems	_____	Family problems	_____

Your grades in school were generally (Circle): A B C D F

Were you ever held back a grade? Y/N Which grade(s)

Why? _____

Where you ever told you had a learning disability or ADHD? Y/N

(Explain)

Were you ever placed in a special class? Y/N Which grade(s) Why?

Describe your school activities and awards

Looking back, what did you like most about school?

What did you like least about school?

28. Are you a highschool graduate? Y/N What School? _____

Location? _____ Year graduated _____ GED? Y/N

29. Did you work outside the home before you left highschool? Y/N

What types of jobs did you have?

30. College or specialized training:

Where	Degrees/Credentials	When
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31. Please account for the last five jobs (even if the same employer) or the jobs you've held for the past fifteen years.

List your most recent job first.

<u>Employer</u>	<u>Job Title</u>	<u>City</u>	<u>Dates of employment</u>
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Fainting spells	___	___	Blackouts	___	___
Hearing loss	___	___	Swelling of joints	___	___
Heart pounding	___	___	Problems with family	___	___
Paralysis	___	___	Financial Problems	___	___

37. Please list all past or present Employment Injuries or Worker's Compensation Claims or Personal Injuries.(such as a car accident)

38. Have you ever been fired or had conflicts with coworkers or supervisors?
 Yes _____ No _____ If yes, please describe in detail _____

39. Where were you born? _____

40. Where were you raised? _____

41. Are you represented by an attorney? Yes _____ No _____ If yes, please provide their name, address, and phone number.

42. What are your plans for the future?
