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| **Agency Completing Form:** |  |
|  |
| **Date:**  |  |  |  |
|  | Month | Day | Year |
| **Name:** |  |  |  |
|  | Last | First | Middle |
| **Address:**  |  |  |  |  |
|  | Street | City | State | Zip |
| **Phone no.:**  |  | **Length of time at address:** |  |
|  |  |  |  |
| **Primary language spoken at home:** |  |
| **Reason for seeking services:** |  |
|  |
|  |  |  |  |  |  |
| **Are you seeking services for any of the following reasons? Check all that apply.** |
|  | Headache |   | Hearing voices |   | Isolating yourself |  | Distrustful of others |
|  | Dizziness |   | Choking feeling |   | Lack of motivation |  | Self-inflicted wounds |
|  | Nightmares |   | Can’t keep jobs |   | Can’t make friends |  | Fear of losing control |
|  | Flashbacks |   | Stomach trouble |   | Can’t keep friends |  | Conflict within family |
|  | Binge eating |   | Tremors or tics |   | Financial problems |  | Nervous around strangers |
|  | Always tired |   | Sexual problems |   | Can’t make decisions |  | Fear things you shouldn’t |
|  | Weight change |   | Trouble sleeping |   | Strange experiences |  | Loss or increase in appetite |
|  | Bowel trouble  |   | Ready to explode |   | Problems with anger |  | Thoughts of harming others |
|  | Feeling tense  |   | Panicky feelings |   | Thoughts of suicide |  | Can’t get interested |
|  | Blurred vision |   | Unusual thoughts  |   | Trouble with memory |  | Trouble concentrating |
|  | Muscular aches |   | Feel like crying |   | Feeling worthless |  | Feeling depressed |
|  | Intrusive or senseless thoughts or impulses |   | Bad smells others don’t smell |   | Excessive checking, list making, washing, etc. |  |  |
|  |  |  |  |  |  |
| **How long have these things been bothering you?** |  |
|  |  |  |  |  |  |
| **Have you ever received treatment for emotional problems or substance use problems?** |  | Yes |  | No |
| **If “Yes”, list when and where you were treated:** |
|  |  |  |  |  |  |  |
| **Year** |  | **Therapist / Agency** |  | **City & State** |  | **How long?** |
|  |  |  |  |  |  |  |
| **Year** |  | **Therapist / Agency** |  | **City & State** |  | **How long?** |
| **Any past suicide attempts?** |  | Yes |  | No | **If “yes”, when?** |  |
|  |
| **Any psychiatric or medical hospitalizations?** |  | Yes |  | No |  |
| **If “yes”, when and where?** |  |
|  |  |
| **Current psychiatric and medical medications used and their dosage:** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
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| **Have you ever, or are you now, using substances of abuse, including Marijuana?**  |  | Yes |  | No |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Frequency of use and method:** |  |
|  |  |
|  |  |
|  |  |  |  |  |  |
| **Have you ever, or are you now, experiencing any of the following medical problems? Check all that apply.** |
|  | Asthma |   | Sinus trouble |   | Anemia or blood disease |
|  | Cancer |  | Eye infection |   | Dermatitis / skin disease |
|  | Stroke |  | Kidney disease |   | Seizure disorder / epilepsy |
|  | Diabetes |  | Rheumatic fever |   | High blood pressure / hypertension |
|  | Hay fever  |  | Thyroid problems |   | Stomach ulcers or ulcer disease |
|  | Hepatitis |  | Hearing problems |   | Special need (visual or hearing) |
|  | Blindness |  | Speech difficulty |   | Head injury |
|  | Difficulty walking |  | Tuberculosis |   | Physical disabilities |
|  | Lung disease |  | Loss of consciousness |   | Heart disease |
|  | Arthritis (rheumatoid)  |  | Other:  |
|  | Currently pregnant | Due Date: |  |
|  | Surgeries | Dates: |  |
|  |  |  |  |  |  |
| **Date of last physical exam:**  |  |  |  |
|  | Month | Day | Year |
| **Are you currently seeing a medical doctor?** |  | Yes |  | No |  |
| **Name(s) of doctor(s):** |  |
| **Name of Agency:** |  |
| **Phone Number:** |  |
|  |
| **Date last seen:**  |  |  |  |
|  | Month | Day | Year |
| **How often seen:** |  |
| **Medication / food allergies:** |  |
|  |  |
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