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| **Agency Completing Form:** | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Date:** | | | | |  | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | Month | | | | | | | | | | | | | | | | | | | Day | | | | | | | | | | | | | | | | | | | Year | | | | | | | | | | | | |
| **Name:** | | | | |  | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | Last | | | | | | | | | | | | | | | | | | | First | | | | | | | | | | | | | | | | | | | Middle | | | | | | | | | | | | |
| **Address:** | | | | |  | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  |
|  | | | | | Street | | | | | | | | | | | | | | | | | | | | | | City | | | | | | | | | | | | | | | | | | | | | State | | | | | | | Zip |
| **Phone no.:** | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Length of time at address:** | | | | | | | | | |  | | | | | | | | | | | | |
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| **Primary language spoken at home:** | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Reason for seeking services:** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **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. | | | | | | | | | | | | | |  | |  | | | | | | | | |
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| **How long have these things been bothering you?** | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Have you ever received treatment for emotional problems or substance use problems?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | Yes | | | | | | |  | | | No | |
| **If “Yes”, list when and where you were treated:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Year** | | |  | **Therapist / Agency** | | | | | | | | | | | | | | | | | | | | | | |  | | | **City & State** | | | | | | | | | | | | | | | | | | |  | | | **How long?** | | | |
|  | | |  |  | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | | | | | | | | | | | | | | | | |  | | |  | | | |
| **Year** | | |  | **Therapist / Agency** | | | | | | | | | | | | | | | | | | | | | | |  | | | **City & State** | | | | | | | | | | | | | | | | | | |  | | | **How long?** | | | |
| **Any past suicide attempts?** | | | | | | | | | |  | | Yes | | | |  | | No | | | **If “yes”, when?** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
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| **Any psychiatric or medical hospitalizations?** | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | Yes | | |  | No | | | |  | | | | | | | | | | | | | | | | | | |
| **If “yes”, when and where?** | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **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 | | | | | |  | | |
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| **Frequency of use and method:** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **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: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **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:** | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Date last seen:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |  | | | | | | | | | |
|  | | | | | | | | Month | | | | | | | | | | | | | | | | | | | | | Day | | | | | | | | | | | | | | | | | Year | | | | | | | | | |
| **How often seen:** | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medication / food allergies:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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