Name_____ Date of Birth_____
(first) *(last)* *(include year)*

Preferred Name _____ Date of Initial Appointment _____

PRESENTING PROBLEMS

Reason for seeking therapy _____

Have you previously suffered from these problems? Yes No *(circle)*

If yes, when? _____

_____

If yes, enter previous therapist(s) seen for the problems, and describe treatment _____

_____

_____

What makes things worse? _____

What makes things better? _____

CURRENT SYMPTOMS

(check all that apply)

- ☐ Anger
- ☐ Anxiety
- ☐ Appetite Issues
- ☐ Avoidance
- ☐ Crying Spells
- ☐ Depression
- ☐ Excessive Energy
- ☐ Fatigue
- ☐ Guilt
- ☐ Hallucinations
- ☐ Impulsivity
- ☐ Irritability
- ☐ Libido Changes
- ☐ Loss of interest
- ☐ Mood Swings
- ☐ Panic attacks
- ☐ Racing Thoughts
- ☐ Risky Activity
- ☐ Sleep Changes
- ☐ Suspiciousness

MEDICAL HISTORY

Allergies/Adverse Reactions: *(include medication, environmental, and food)* _____

_____

Exercise: *(frequency and type)* _____

_____

Mental Health:

Previous mental health treatment/diagnoses _____

_____

Previously treated by *(name and clinic)* _____

_____

Dates treated _____

Previous medications _____

_____

_____

Medical Conditions: *(past and present)* _____

_____

_____

_____

Surgeries: _____

_____

Presently, are you taking any medications? Or supplements? *(list)* _____

_____

_____

_____

FAMILY HISTORY

How is your relationship with your mother? _____

_____

How is your relationship with your father? _____

_____

Siblings and their ages:

Brothers and ages _____

_____

Sisters and ages _____

_____

Did your parents divorce? _____ If yes, how old were you? _____

Did your parents remarry? _____ If yes, how old were you? _____

Who raised you? _____ Where did you grow up? _____

Were you adopted? _____ If yes, at what age? _____

Family member medical/mental conditions: *(parents, grandparents, siblings, or other notable cases)*

Family Member _____ Condition _____

Family Member _____ Condition _____

Family Member _____ Condition _____

Family Member _____ Condition _____

Family Member _____ Condition _____

How are the relationships in your support system? *(friends, extended family, etc.)* _____

_____

PRESENT SITUATION

Work _____

_____

Are you married? _____ If yes, specify date of marriage _____

Are you divorced? _____ If yes, specify date of divorce _____

Have you been widowed? ____ If yes, specify date _____

Prior marriages? _____ If yes, how many? _____

What is your sexual orientation? _____

How is your relationship with your partner? _____

_____

Do you have child(ren)? ____ If yes, how is your relationship with your children? _____

_____

_____

Are you a member of a religion/spiritual group? _____

Have you ever been arrested? If yes, when and why? _____

ABUSE HISTORY

Have you ever been abused physically, emotionally, sexually? *(circle)*

If yes, describe and explain what happened: _____

_____

_____

SUBSTANCE USE

Have you ever tried the following?

- ☐ Alcohol
- ☐ Tobacco
- ☐ Marijuana
- ☐ Hallucinogens (LSD)
- ☐ Heroin
- ☐ Methamphetamines
- ☐ Cocaine
- ☐ Stimulants (Pills)
- ☐ Ecstasy
- ☐ Methadone
- ☐ Tranquilizers
- ☐ Pain Killers
- ☐ Fentanyl
- ☐ Opioids
- ☐ Other _____

"CAGE-AID" (Adult) Questionnaire

Have you ever: *(circle)*

Felt you ought to CUT down on your drinking? ..... Yes No

Had people ANNOY you by criticizing your alcohol/drug use? ..... Yes No

Felt bad or GUILTY about your alcohol/drug use? ..... Yes No

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

Would you or someone else say you had problems with other addictions, i.e., gambling, shopping, pornography, compulsive behaviors? ..... Yes No

Have you ever been treated for drug/alcohol abuse? If yes, when? _____ Yes No

Do you vape or smoke cigarettes? If yes, how many per day? _____ Yes No

Do you drink caffeinated beverages? If yes, how many per day? _____ Yes No

Have you ever abused prescription drugs? If yes, which ones? _____ Yes No

STRENGTHS AND ABILITIES

(check boxes that apply)

☐ I am very motivated about treatment.

☐ I have some positive plans and goals for my future.

☐ I am willing to do whatever it takes to be more functional and healthy.

☐ I am able to recognize my problems and areas of my life that I want to change.

☐ I have good work skills and experience.

☐ I have good interpersonal skills.

☐ I have good emotional management skills.

NEEDS

What do you want to accomplish or address in therapy? *(check all that apply, or add your own)*

☐ More thorough understanding of my problems

☐ Education regarding my health and how to recover

☐ Emotional management skills

☐ Coping skills

☐ Improvement in my communication skills

☐ Improvement in my interpersonal skills

☐ Anger management skills

☐ Personal safety plan

☐ Parenting skills

☐ Obtaining and keeping a job

☐ Relapse prevention

☐ Other _____

ADDITIONAL INFORMATION

Is there anything else you want the therapist to know? _____

_____