PERSONAL HISTORY FORM

□ MENTAL HEALTH  □ SUBSTANCE ABUSE  □ BOTH  CLIENT ID # ______

FORM COMPLETED BY (If someone other than client) ______________________________________

A) What brought you into treatment: ______________________________________________________

B) What are your expectations for treatment: ________________________________________________

C) Prior treatment experiences (Dates and Location): _________________________________________

D) Name of Primary Care Physician: ___________________________ Phone: ________________________

E) Current Living Arrangements:

1. □ House  □ Group Living  □ Apartment  □ Other (Specify) _____________________________

2. □ Alone  □ With Family  □ Unrelated Significant Other

I. CLIENT INFORMATION (past and present)

1) Treatment Experiences

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Inpat./Outpt/ IOP</th>
<th>When</th>
<th>Where</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling/Psychiatric treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Suicidal thoughts/Attempts</td>
<td></td>
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<tr>
<td>Drug/alcohol treatment</td>
<td></td>
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</tr>
<tr>
<td>Involvement with self-help groups (e.g. AA, Al-Anon, Overeaters Anonymous)</td>
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<td></td>
</tr>
</tbody>
</table>

2) Presenting Problem (Check all boxes that apply)

- □ Medical/Organic condition
- □ Depression
- □ Mania
- □ Chemical Abuse/Dependency
- □ Delusions/Hallucinations
- □ Family Issues
- □ Relationship Issues
- □ Other (please elaborate)
- □ Anxiety
- □ Aggressive Behavior
- □ Suicidal Ideation’s
- □ Self-destructive Behavior
- □ Anger
- □ Life Decision
- □ Uncertain
### 3) Symptoms

Any recent changes in:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleeping patterns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Activity Level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating Patterns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Disposition</td>
<td></td>
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<tr>
<td>Behavior</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Energy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased tension</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If yes to any of the above, please describe

Are you in physical pain  □ yes  □ no  if yes where/what kind

If yes please rate pain________________________ 0=none  5=mild(tolerable)  10=severe(referral)

**THERAPY IMPLICATIONS:**

---

### II. INFORMATION ABOUT FAMILY / SIGNIFICANT OTHERS; past and present

#### 1. Family Constellation

<table>
<thead>
<tr>
<th>NAME</th>
<th>CURRENT AGE</th>
<th>CURRENTLY LIVING</th>
<th>CURRENTLY LIVING WITH YOU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client</td>
<td></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Significant Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significant Others: (Brothers, Sisters, Grandparents Step-relatives, Half-relatives)</td>
<td>Specify Relationship</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Page 2
Z:CENTERN FOR COUNSELING/FORMS/PERSONAL HISTORY
2) FAMILY/EXTENDED FAMILY HISTORY

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Inpt/Outpt/IOP</th>
<th>When</th>
<th>Where</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling/Psychiatric</td>
<td></td>
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<tr>
<td>treatment</td>
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<tr>
<td>Suicidal thoughts/attempts</td>
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<tr>
<td>Drug/alcohol treatment</td>
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<tr>
<td>Involvement with self-help groups</td>
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</tr>
</tbody>
</table>

3) Family History

1. What City/State were you born? ________________________________
2. Where did you grow-up? ________________________________
3. Who raised you as a child? ________________________________

4) Parental Information

- □ Parents legally married
- □ Mother remarried (number of times)
- □ Parents ever separated
- □ Father remarried (number of times)
- □ Parents ever divorced

Describe relationships with parents, step-parents

1. As a child ________________________________________
2. Currently ________________________________________

5) SIBLING INFORMATION

Number of living siblings/step siblings __________ Number of deceased siblings/step-siblings

What position are you in the order of siblings (oldest, 2nd, 3rd, youngest, etc.) ________________________

Describe relationships with siblings:

1. As a child ________________________________________
2. Currently ________________________________________

- □ Family will be involved in treatment
- □ Family uninvolved

Why/Why Not: ________________________________________
6) **Marital Information**

- Single
- Unmarried and living with significant other. Length of time ________________
- Legally married: Length of time ________________
- Separated: Length of time ________________
- Divorced: Length of time ________________
- Divorce in process: Yes ☐ No ☐
- Widowed: Length of time ________________

Are there problems in this relationship (check all that apply)
- Money ☐ Chemical Dependency ☐
- Sexual ☐ Mental illness ☐
- Physical Abuse ☐ Religion ☐
- Child rearing/discipline issues ☐ Other ☐

**THERAPY IMPLICATIONS:**

---

III. **SOCIAL INFORMATION**

1) **Support System** (check all that apply)

- Adequate social support ☐
- Recent move / relocation ☐
- Conflict with peers ☐
- Transportation problems ☐
- Lack of knowledge of resources ☐
- Isolative ☐
- Problems establishing / maintaining relationships ☐

Please list involvement in community resources (e.g. WIC, CMH, Day treatment, groups) ________________

**THERAPY IMPLICATIONS:**

---

2) **Sexuality**

What is your sexual preference ☐ Male ☐ Female ☐ Both ☐ Uncertain

Have you been tested for HIV ☐ Yes ☐ No

Are there sexual issues that you would like to discuss with your therapist? Yes ☐ No ☐

Have you ever been sexually and/or physically abused? Yes ☐ No ☐

**THERAPY IMPLICATIONS:**

---

3) **Interests/Hobbies**

Art ________________ Book/Films ________________
Music ________________ Physical Fitness ________________
Crafts ________________ Outdoor Activity ________________
Sports ________________ Diet/Health ________________

Current Memberships (church, clubs, organizations)

Do you participate in any cultural activities related to your ethnic background? Yes ☐ No ☐

**THERAPY IMPLICATIONS:**

---

4) **Spirituality**

Do you believe in a god or a power greater than yourself? Yes ☐ No ☐

What religion were you raised? ________________

What religion are you currently affiliated? ________________

At this point in your life, what is most important to you? ________________

**THERAPY IMPLICATIONS:**

---
IV. **EDUCATION** (check all that apply)

- High school diploma (GED)  
-Currently enrolled: Last grade completed ____________________________
- Did not complete high school: last grade completed ____________________
- Vocational training: Training completed, type __________________________  
-Currently enrolled
- College: Degree earned, type __________________________  
-Currently enrolled/# of years completed_______
- Special circumstances (e.g. learning disabilities, gifted programs, special education, etc.)

THERAPY IMPLICATIONS: _____________________________________________

V. **EMPLOYMENT/VOCATIONAL** (Beginning with most recent job, give employment history, include homemaker experience)

<table>
<thead>
<tr>
<th>Employer</th>
<th>Dates</th>
<th>Job Description</th>
<th>Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

THERAPY IMPLICATIONS: _____________________________________________

VI. **MILITARY**

- Branch ____________________________  
- Type of Discharge
- Date drafted/enlisted _____________  
- Rank at Discharge
- Combat experience □ Yes □ No  
- Date of Discharge _________  
- Where ______________________

THERAPY IMPLICATIONS: _____________________________________________
VII. **LEGAL DATA**

Are you presently on probation or parole: □ Yes □ No

If yes reason ____________________________ From ___________ To ________________

**Current Status:**

Are you currently involved in any active legal cases (traffic, civil, criminal): □ Yes □ No

If yes, please describe and indicate the court hearing/trial date ________________________

---

**Past History** (adolescent and adult)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
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<tr>
<td>☐</td>
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<tr>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

If yes to any of the above, please complete the following

<table>
<thead>
<tr>
<th>Charges</th>
<th>Date</th>
<th>Where</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**THERAPY IMPLICATIONS:**

---

**VIII. Nutritional Assessment**

Please circle the answer or indicated number and total the score from both columns at the bottom.

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>Yes 2</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have an illness/condition that made you change the type/amount of food you eat?</td>
<td>Yes=2</td>
<td>No</td>
</tr>
<tr>
<td>Do you eat at least two or more meals per day?</td>
<td>Yes</td>
<td>No=3</td>
</tr>
<tr>
<td>Do you eat fruits or vegetables, or milk products every day?</td>
<td>Yes</td>
<td>No=2</td>
</tr>
<tr>
<td>Do you have 3 or more drinks of beer, liquor, or wine almost every day?</td>
<td>Yes=2</td>
<td>No</td>
</tr>
<tr>
<td>Do you have teeth or mouth problems that make it hard for you to eat?</td>
<td>Yes=2</td>
<td>No</td>
</tr>
<tr>
<td>Do you always have enough money to buy the food you need?</td>
<td>Yes</td>
<td>No=4</td>
</tr>
<tr>
<td>Do you eat alone most of the time?</td>
<td>Yes=1</td>
<td>No</td>
</tr>
<tr>
<td>Do you take 3 or more prescription or over-the-counter drugs?</td>
<td>Yes=1</td>
<td>No</td>
</tr>
<tr>
<td>Have you lost or gained 10 lbs. in the last six months?</td>
<td>Yes=1</td>
<td>No</td>
</tr>
<tr>
<td>Are you always physically able to shop, cook, and/or feed yourself?</td>
<td>Yes</td>
<td>No=2</td>
</tr>
</tbody>
</table>

**TOTAL SCORE** ______________________

0-2= Low Risk  3-5= Moderate Risk  6-21= High Risk*  *Referral

**THERAPY IMPLICATIONS:**

---
IX TRAUMA

Any history of trauma, abuse, neglect or exploitation? □ No □ Yes

If yes:  When and type __________________________________________________________

____________________________________________________________________________

THERAPY IMPLICATIONS:____________________________________________________________________

X Alcohol/Substance Use

Substance preferred ______________________________________________________________

Date of last drink ______________________ / Date of last drug use ____________________________

Type and amount of drink at last episode  □ Beer ______ oz  □ Wine _____ oz  □ Liquor _____ oz

Age drinking/ drug use began _______________________________________________________

Type of alcohol preferred: □ Beer  □ Wine  □ Liquor

How often do you drink/use drugs? □ Daily  □ Weekly  □ Monthly  □ Other __________________

Have you ever had any legal problems related to your use of alcohol/drugs? □ Yes □ No

Have you ever had any relationship problems related to your use of alcohol/drugs? □ Yes □ No

***Has drinking or drug use ever become a problem? □ Yes □ No

***If YES, please complete next page. (Substance Abuse Addendum)

If NO go to page 10

THERAPY IMPLICATIONS:____________________________________________________________________
### I. USAGE HISTORY

<table>
<thead>
<tr>
<th>Drug type</th>
<th>Method of use</th>
<th>Age first used</th>
<th>Age of regular, daily use</th>
<th>Date last used</th>
<th>Last 48 hours</th>
<th>Last 30 days</th>
<th>Last year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. DEPRESSANTS</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Alcohol (beer, wine, liquor)</td>
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<tr>
<td>Anti-Anxiety Agents (Valium, Librium, Tranxene, Xanax, Ativan, Serax, etc.)</td>
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<tr>
<td>Barbiturates (Phenobarbital, Tuinal, Seconal, etc.)</td>
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<tr>
<td>Others (Methaqualone, Paraldehyde, Equanil, Miltown, muscle relaxants, etc.)</td>
<td></td>
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<tr>
<td><strong>B. NARCOTICS</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>(Heroin, Opium, Morphine, Codeine (Tylenol #3/#4, Cough Syrup), Methadone, Dilaudid, Percodan, Darvon, Talwin, etc.)</td>
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<tr>
<td><strong>C. STIMULANTS</strong></td>
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<tr>
<td>Amphetamines (Benzedrine, Dexedrine, Ritalin, etc.)</td>
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<tr>
<td>Cocaine/Crack</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Caffeine</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Nicotine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>D. CANNABIS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Marijuana, Hashish)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>E. INHALANTS</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(glue, poppers, gasoline, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>F. HALLUCINOGENS</strong></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**THERAPY IMPLICATIONS:**
ALCOHOL/DRUG RELATED PROBLEMS/BEHAVIORS/SYMPTOMS LIST

Please check all that apply.

<table>
<thead>
<tr>
<th>PHYSICAL</th>
<th>EMOTIONAL</th>
<th>BEHAVIORAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blackouts</td>
<td>Depression</td>
<td>A.M. Use</td>
</tr>
<tr>
<td>Memory Problems</td>
<td>Confusion</td>
<td>Sneaking</td>
</tr>
<tr>
<td>Tremors/Shakes</td>
<td>Concentration Problems</td>
<td>Gulping</td>
</tr>
<tr>
<td>Seizures</td>
<td>Anxiety</td>
<td>Loss of Control</td>
</tr>
<tr>
<td>DT=s</td>
<td>Irritability/Restlessness</td>
<td>Relief Use</td>
</tr>
<tr>
<td>Hallucinations</td>
<td>Aggressiveness</td>
<td>Impulsive Use</td>
</tr>
<tr>
<td>Overdose</td>
<td>Mood Swings</td>
<td>Use less than before</td>
</tr>
<tr>
<td>Appetite Problems</td>
<td>Impulsivity</td>
<td>Use more than before</td>
</tr>
<tr>
<td>Nausea/Vomiting</td>
<td>Euphoria</td>
<td>Use despite negative Consequences</td>
</tr>
<tr>
<td>Sleep Problems</td>
<td>Relaxation</td>
<td>Associate with using friends</td>
</tr>
<tr>
<td>Sexual Problems</td>
<td>Mood Swings</td>
<td>Plan activities around use</td>
</tr>
<tr>
<td>Injury</td>
<td>Impulsivity</td>
<td>Loss of interest in activities</td>
</tr>
<tr>
<td>Accidents</td>
<td>Extreme Jealousy</td>
<td>Change in work/school performance</td>
</tr>
<tr>
<td>Other Medical Problems</td>
<td>Feelings of Guilt/Shame</td>
<td>Work/school lateness/absenteeism</td>
</tr>
<tr>
<td>Other</td>
<td>Suicidal Thoughts</td>
<td>Job loss due to use</td>
</tr>
<tr>
<td></td>
<td>Homicidal Thoughts</td>
<td>Frequent arguments</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>Separation/divorce</td>
</tr>
</tbody>
</table>

If any of the above are checked off, please describe:

III. SUBSTANCE ABUSE FAMILY HISTORY

Please describe the alcohol/drug problems of others in your family, past and present. Also describe treatment and recovery experience.

<table>
<thead>
<tr>
<th>WHO/RELATIONSHIP</th>
<th>PROBLEM TYPE</th>
<th>TREATMENT/RECOVERY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

- 9 -
XI. MEDICAL INFORMATION (past and present)

1. Recent Treatment History

<table>
<thead>
<tr>
<th>Date</th>
<th>Reason</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last physical check-up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last Doctor’s visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last Dental visit</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Review of Past/Present Conditions

Please check any of the following medical problems you have, or have had in the past:

- [ ] Adrenal problems
- [ ] Head Injury/Loss of Consciousness
- [ ] Anemia
- [ ] Brain Tumor

- [ ] Diabetes
- [ ] Kidney/Bladder problems
- [ ] Lung problems
- [ ] Cancer

- [ ] Thyroid problems
- [ ] High Blood Pressure
- [ ] Heart problems
- [ ] Glaucoma

- [ ] Seizures/Epilepsy
- [ ] Stroke
- [ ] Allergies
- [ ] Asthma

- [ ] Meningitis or Encephalitis
- [ ] Sexually transmitted disease
- [ ] Fever

If yes to any of the above, please describe and give dates:

3) Current Medical Symptoms/Problems:

Please check all that pertain to you now:

EYES

- [ ] Double Vision
- [ ] Eye pain
- [ ] Problems with vision

EARS

- [ ] Hearing Aid
- [ ] Buzzing/Ringing in ears
- [ ] Problems with balancing
- [ ] Problems with hearing

NOSE

- [ ] Nose bleeds
- [ ] Stuffy nose

MOUTH

- [ ] Loss of taste
- [ ] Problems with teeth
- [ ] Dentures

RESPIRATORY

- [ ] Shortness of breath
- [ ] Chronic cough
- [ ] Sputum/mucus production
- [ ] Positive TB test
- [ ] Coughing up blood

SKIN/Joint/MUSCLE

- [ ] Changes in skin
- [ ] Changes in nails
- [ ] Changes in hair
- [ ] Skin rash
- [ ] Skin itchy/dry
- [ ] Cramps in legs/arms
- [ ] Stiff/swollen joints
- [ ] Difficulty walking

GASTROINTESTINAL

- [ ] Difficulty swallowing
- [ ] Heartburn
- [ ] Nausea
- [ ] Vomiting
- [ ] Diarrhea
- [ ] Constipation
- [ ] Blood in stool
- [ ] Black tarry stool
- [ ] Abdominal pain

GENITO/URINARY

- [ ] Pain/burning with urination
- [ ] Frequent urination at night
- [ ] Bloody/brown urine
- [ ] Difficulty starting urine flow
- [ ] Constant need to urinate

NERVOUS SYSTEM

- [ ] Headaches
- [ ] Numbness
- [ ] Fainting spells
- [ ] Convulsions/seizures
- [ ] Memory problems
- [ ] Coordination problems
- [ ] Tremor/shakes
- [ ] Loss of movement
- [ ] Loss of sensation

GENERAL HEALTH

- [ ] Overweight
- [ ] Underweight
- [ ] Chills
- [ ] Fever
- [ ] Tire easily
- [ ] Night/day sweats

CARDIOVASCULAR

- [ ] High blood pressure
- [ ] Low blood pressure
- [ ] Heart skips a beat
- [ ] Palpitations
- [ ] Fast heart rate
- [ ] Chest pains
- [ ] Swollen ankles

FEMALES ONLY

- [ ] Menstrual irregularities
- [ ] Problem pregnancy
- [ ] Miscarriage #________
- [ ] Abortion #________
- [ ] Premenstrual problems
- [ ] Infertility
- [ ] Currently pregnant

- [ ] Menopause
4) **Medication and Drug Use**

Include prescription, non-prescription, and illegal drugs

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Prescribed</th>
<th>Prescribing Physician</th>
<th>Date 1st used</th>
<th>Date last used</th>
<th>Amount last used</th>
<th>Used in past 48 hr</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Any history of drug overdose: □ Yes □ No If yes, please describe:

Any medication allergies? □ Yes □ No If yes, please describe:____________________________________________________

Do you believe you would benefit from any of the following?

□ Anger Management Education Series □ Substance Abuse Education Series □ Grief Group

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STAFF USE ONLY

Client currently being treated by Primary Care Physician for symptoms checked on page 10 □ yes □ no □ n/a

Referred for physical □ yes □ no

__________________________________________

CLINICIAN SIGNATURE/CREDSENTS

__________________________________________

DATE

__________________________________________

PSYCHOLOGIST SIGNATURE

__________________________________________

DATE

Physician □ agrees □ disagrees with referral

If disagree reason ________________________________________________________________

__________________________________________

__________________________________________