Name______________________________
First Last Middle

Marital/relationship history

First ____
Spouse's name Spouse's age Your age Date when marriage ended

Second____
Spouse's name Spouse's age Your age Date when marriage ended

Third____
Spouse's name Spouse's age Your age Date when marriage ended

Children (Indicate which are from a previous marriage or relationship with the letter P in the last column)

____
Name age Sex problems?

Family-of-origin history

Father____
Name Age (or age at death) Education Occupation

Mother____
Name Age (or age at death) Education Occupation

Stepparent____
Name Age (or age at death) Education Occupation

Brothers____
Name Age (or age at death) Education Occupation

Sisters____
Name Age (or age at death) Education Occupation

OCCUPATIONAL INFORMATION

____

1. Highest level of education completed: ❑ Some high school ❑ GED ❑ Some college ❑ Associate ❑ Bachelors ❑ Masters ❑ Doctorate ❑ Other:

____

2. Are you currently employed? ❑ Yes ❑ No
If yes, list your occupation and your current employer:

____

If yes, how happy are you in your current position: ___________________________

PERSONAL HEALTH AND SOCIAL INFORMATION

1. Overall, how is your physical health at present? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

2. Please list any current and/or persistent physical symptoms or health concerns:

____

____

3. List all significant health problems and initial dates of diagnoses:

____

4. List all current medications and dosages (including over-the-counter and naturopathic):

____
Medication Name Dosage Prescribed Dosage Generally Taken (if different)

____

____

5. Are you currently or have you previously received psychiatric (medical) or psychological (counseling) assistance? ❑ Yes ❑ No
If yes, please explain when and with whom for all current and previous assistance:

____

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6. Are you having any problems with your sleep habits? ❑ No ❑ Yes (check all applicable)

❑ Sleeping too little (avg. amount):________________________ ❑ Poor quality sleep
❑ Sleeping too much (avg. amount): ______________________ ❑ Disturbing dreams
❑ Early morning wakening (avg. wake time): ________________ ❑ Difficulty getting to sleep
❑ Other___________________________

7. How many times per week do you exercise?_____ Approx. how long each time?_________

8. Are you having any difficulty with appetite or eating habits? ❑ Yes ❑ No
If yes, circle all applicable: ❑ Eating less ❑ Eating more ❑ Binging ❑ Restricting
Have you experienced significant weight change in the last 2 months? ❑ Loss ❑ Gain ❑ Neither

9. How often do you engage in recreational drug use? ❑ Daily ❑ Weekly ❑ Monthly ❑ Rarely ❑ Never

Which drugs (street and/or prescription?) ____

10. Do you currently have suicidal thoughts? ❑Frequently ❑Sometimes ❑Rarely ❑Never

11. In the past year, have you experienced any significant life changes or stressors?

❑Yes ❑No
If yes, please explain:____

RELIGIOUS/SPIRITUAL INFORMATION

Do you consider your faith/religion meaningful in your life currently? ❑ Yes ❑ No

If yes, what is your faith affiliation? ____