Printed Name: _____Birthdate: _____

PATIENT INFORMATION

Client's Full Name: _____Today's Date:_____

Birth Date: _____Age:_____ SSN #: _____

Martial Status: _____ Driver's License #: _____

Address: _____

City:_____ State: _____Zip Code:_____

Provide numbers and Email you give us permission to call and leave a message

Home Phone: _____ Mobile Phone: _____

Work Phone: _____Email:_____

Employment or School (Grade if Student): _____

Referred By: _____ Telephone: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____ Phone: _____

Primary Care Physician _____Telephone: _____

INSURANCE INFORMATION (If Applicable)

Insurance Company: _____ Name of Insured: _____

Insured's SSN #: _____ Insured's DOB: _____

Insured's Policy #: _____Insured's Group #: _____

Insured's Employer: _____Insured's Relationship To Client: _____

Printed Name: _____Birthdate: _____

CHIEF COMPLAINT

What symptoms you are having?

_____

_____

_____

_____

Have you experience the following symptoms/problems (Please Circle):

Concentration Hopelessness Depressed Panic Fears Guilt Self-Control

Harm to Self Suicidal Concerns Harm to Others Impulsivity High Energy Low Energy

Hyperactive Attention Anger Temper Nervousness Anxiety Stress

Attention Difficulties Sleep Problems Dreams Nightmares Grief

Health Problems Appetite/Weight Eating/Food Trouble Bowel Trouble

Stomach Trouble Sexual Concerns Drug Use Alcohol Use Headaches

Memory Thoughts Abuse Trauma Shyness Crying Spells Unhappiness

Self-Esteem Spiritual Concerns Lack of Motivation Legal Matters Career Choices

Education/Academic Making Decisions Meaninglessness Bedwetting

changes in sleeping pattern/appetite

PAST PSYCHIATRIC HISTORY – PLEASE CIRCLE AND EXPLAIN

Have you been diagnosed with a mental disorder, if so what is your diagnosis? (Yes/No)

_____

What psychiatric medication, if any, have you been on in the past or are taking now?

_____

Printed Name: _____Birthdate: _____

Have you ever been hospitalized in a psychiatric or mental health hospital? (Yes/No)

_____

Are you currently or ever been in talk therapy? (Yes/No) _____

_____

Have you ever had any suicide attempts? (Yes-Explain/No)_____

_____

Have you ever had any self-injurious behavior (self cutting, head banging etc.)? (Yes-Explain/No):

_____

MEDICAL HISTORY – PLEASE CIRCLE AND EXPLAIN

Do you have any medical illness? (Yes-Explain/No): _____

_____

Have you ever been admitted to a physical (not mental) hospital? (Yes-Explain/No): ___

_____

Have you had past surgeries? (Yes-Explain/No): _____

_____

Have you ever been hit in the head and lost consciousness? (Yes-Explain/No):_____

_____

If you are a woman, any past abortions or miscarriages? (Yes-Explain/No): _____

Printed Name: _____Birthdate: _____

_____

Are you allergic to any medications? (Yes-Explain/No): _____

_____

What medications (prescription or over-the counter) are you taking? (Yes-Explain/No):

_____

_____

FAMILY HISTORY - PLEASE CIRCLE AND EXPLAIN

Is there anyone in your family whom has been placed in a mental hospital? (Yes-Explain/No): _____

_____

Does any relative take medications for mental illness? (Yes-Explain/No): _____

_____

Anyone in your family with alcohol or drug dependence? (Yes-Explain/No): _____

_____

Any family history of mental retardation or learning problems? (Yes-Explain/No): _____

_____

SUBSTANCE ABUSE – PLEASE CIRCLE AND EXPLAIN

Are you addicted to any drugs, cigarettes, or alcohol? (Yes-Explain/No): _____

_____

Have you ever been arrested for using illegal or legal drugs? (Yes-Explain/No): _____

_____

Do any of your loves ones think you have a drug problem? (Yes-Explain/No): _____

Printed Name: _____Birthdate: _____

_____

Please Complete the Following Chart

Drug Use	Age at 1st Use	How much did you use at the height of use	Duration of Dependence	Last Date Used	Longest Period of Abstinence
Nicotine					
Alcohol					
Marijuana					
Cocaine/Crack					
Amphetamines					
Hallucinogens					
Ecstasy/Other					
Inhalants					
Heroin					
Barbiturates					
Other					

Means of Obtaining Substance: _____

Motivation for use: _____

Interest in reducing use/abstinence: _____

Problems usage may have caused: _____

Have you ever been in any drug rehab programs? (Yes-Explain/No):_____

Please list medical problems associated with your drug use: _____

Have you experience the following symptoms/problems (Please Circle):

Printed Name: _____Birthdate: _____

DWI Blackouts Seizures Job Loss related to drugs

Incarceration Arrest related to drug

SOCIAL/ SOCIAL/ DEVELOPMENTAL HISTORY– PLEASE CIRCLE AND EXPLAIN

Where you born preterm? (Yes-Explain/No):_____

Prenatal hx. And birth (include pre-natal exposure to alcohol, tobacco and other drugs:

_____

Where there any complications during the birthing process? (Yes/No): _____

_____

Did you mother have any medical problems while pregnant with you? (Yes/No)

_____

Did your mother take any prescribed or illegal drugs when pregnant with you? (Yes/No):

_____

Did you reach all developmental milestones (walking, talking, toilet trained etc.) on time? (Yes/No): _____

Did you have any childhood sexual, physical or emotional abuse? (Yes-Explain/No): ____

_____

Who reared you? _____

How many sisters and brothers do you have? _____

What is your highest level of education? _____

Do you have children? (Yes/No) _____ How Many:_____

Printed Name: _____Birthdate: _____

I certify that all the information provided on this form is correct. I authorize the release of any information concerning my or my child's health care, advice and treatment provided for the purpose of evaluating and administrating claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to LifeStyle Consultant Services. Patient or Parent of minor or Legal Guardian.

Name Printed_____

Signature: _____

Date: _____