**Christian Alzubi, MS, LMFT**

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**650-590-5453**

**COUPLES INTAKE FORM**

*Please complete this form and email it before to our first meeting. If you have any questions or concerns, please feel free to discuss them with me. If you prefer not to answer a question, feel free to leave it blank. All information will be kept confidential within the limits of the law.*

*Section One = Couple Questionnaire (to be complete by together)*

*Sections Two and Three = Individual Questionnaires for both of you to complete*

**General Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Today’s Date: \_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_ Ethnicity/race: \_\_\_\_\_\_\_\_\_\_\_

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (h): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (c): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (w): \_\_\_\_\_\_\_\_\_

Best way to contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Education level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long at job? \_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_

Spouse/Partner name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity/race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (h): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (c): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (w):

Best way to contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Education level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long at job?\_\_\_\_\_\_\_\_

Emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_

Please list the names and ages of any children:

Child name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Child name: Age: \_\_\_\_\_\_\_\_\_

Child name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Child name: Age: \_\_\_\_\_\_\_\_\_

**Section One – Couple Questionnaire**

Relationship Status (check all that apply):

 \_\_\_\_\_ Dating \_\_\_\_\_ Living together

 \_\_\_\_\_ Engaged \_\_\_\_\_ Living apart

 \_\_\_\_\_ Domestic partnership \_\_\_\_\_ Married

 \_\_\_\_\_ Separated \_\_\_\_\_ Divorced

 \_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you two been together as a couple? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If married or in a domestic partnership, since when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If separated or divorced, please indicate the date and reason:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What issues or concerns cause you to seek couples therapy at this time?

History and onset of the above issues (s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please describe if/how the issue(s) impact(s) your functioning, relationships, and responsibilities:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe if/how the issue(s) may be impacting your children (if applicable):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any specific goals you would like to achieve?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any concerns or fears regarding couple’s therapy?

Please describe your strengths as a couple:

What stressors have you overcome in the past as a couple?

Please describe any cultural factors impacting your relationship:

How do you typically handle disagreements and conflicts as a couple?

Have you ever gotten into a physical altercation with one another? Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_

If yes, please describe what occurred and what caused things to escalate:

Are either one of you currently involved in a lawsuit? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

If yes, please describe:

Is there any other important or relevant information that you would like to share?

**Section Two – Individual Questionnaire**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Psychological History**

Have you participated in therapy previously? Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_

If yes, please indicate when and for how long, describe the focus and outcome of treatment:

Are you currently taking any medication(s) for a psychological condition? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please list the medication, dosage, prescribing doctor, and start date(s):

Have you previously taken any medication(s) for a psychological condition? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please list the medication, dosage, prescribing doctor, and start/end date(s):

Have you ever experienced any suicidal thoughts in the past? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe the thoughts and when they occurred:

Are you currently experiencing any suicidal thoughts? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, how often do these thoughts occur and when was the last time?

Have you ever attempted suicide? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe the circumstances that led to the attempt and when it occurred:

Have you ever been hospitalized for an emotional or psychological condition? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe the reason(s) for the hospitalization, when it occurred, and for how long:

Have you experienced any significant emotional losses recently or in the past? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe:

Have you experienced any significant stressors recently? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe:

Have you ever been subjected to verbal, physical, emotional, or sexual abuse? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe:

Have you ever threatened to harm another person or property? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe:

Do you own or have access to any guns or weapons? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please indicate the type of weapon(s) and where it or they are stored:

**Medical History**

Are you allergic to any medications or other substances? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe:

Have you ever been diagnosed with a serious illness? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe:

Have you ever had a serious accident, surgery, head injury, or seizure(s)? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe:

Do you currently have any medical condition(s)? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe:

Are you currently taking any prescription medication(s) for a medical condition? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please list the medication, dosage, and prescribing doctor.

Do you currently use any nonprescription medication(s) or supplements? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe:

Date of your most recent physical examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of your primary care physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe your overall health today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, what and how often?

Do you drink alcohol? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please indicate your preferred type of drink and preferred number of drinks:

Are you currently using any non-prescribed or recreational drugs? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe your use:

Have you ever used any non-prescribed or recreational drugs in the past? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe your use:

Have you ever tried to cut down on your drinking or drug use? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, when and why?

Have you ever participated in drug or alcohol treatment? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe the type of treatment, when it occurred, and the outcome:

**Family History**

Has anyone in your family ever had a psychiatric diagnosis? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please indicate name(s) of the individual(s), diagnosis, and relation to you:

Does anyone in your family have a history of alcohol or drug problems? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please indicate who and describe the nature of their substance use or abuse:

Mother’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_

If deceased, date and cause of death:

Father’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If deceased, date and cause of death:

Please describe your mother’s personality and the nature of your relationship with her:

Please describe your father’s personality and the nature of your relationship with him:

Number of times married: Mother \_\_\_\_\_\_\_\_\_\_\_\_\_ Father \_\_\_\_\_\_\_\_\_\_\_\_\_

Names and ages of any siblings:

Please describe the nature of your relationship(s) with your siblings(s):

Is there any other important or relevant information that you would like to share?

*Thank you for completing this form!*

Signature of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section Three – Individual Questionnaire**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Psychological History**

Have you participated in therapy previously? Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_

If yes, please indicate when and for how long, describe the focus and outcome of treatment:

Are you currently taking any medication(s) for a psychological condition? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please list the medication, dosage, prescribing doctor, and start date(s):

Have you previously taken any medication(s) for a psychological condition? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please list the medication, dosage, prescribing doctor, and start/end date(s):

Have you ever experienced any suicidal thoughts in the past? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe the thoughts and when they occurred:

Are you currently experiencing any suicidal thoughts? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, how often do these thoughts occur and when was the last time?

Have you ever attempted suicide? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe the circumstances that led to the attempt and when it occurred:

Have you ever been hospitalized for an emotional or psychological condition? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe the reason(s) for the hospitalization, when it occurred, and for how long:

Have you experienced any significant emotional losses recently or in the past? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe:

Have you experienced any significant stressors recently? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe:

Have you ever been subjected to verbal, physical, emotional, or sexual abuse? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe:

Have you ever threatened to harm another person or property? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe:

Do you own or have access to any guns or weapons? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please indicate the type of weapon(s) and where it or they are stored:

**Medical History**

Are you allergic to any medications or other substances? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe:

Have you ever been diagnosed with a serious illness? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe:

Have you ever had a serious accident, surgery, head injury, or seizure(s)? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe:

Do you currently have any medical condition(s)? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe:

Are you currently taking any prescription medication(s) for a medical condition? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please list the medication, dosage, and prescribing doctor.

Do you currently use any nonprescription medication(s) or supplements? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe:

Date of your most recent physical examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of your primary care physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe your overall health today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, what and how often?

Do you drink alcohol? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please indicate your preferred type of drink and preferred number of drinks:

Are you currently using any non-prescribed or recreational drugs? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe your use:

Have you ever used any non-prescribed or recreational drugs in the past? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe your use:

Have you ever tried to cut down on your drinking or drug use? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, when and why?

Have you ever participated in drug or alcohol treatment? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please describe the type of treatment, when it occurred, and the outcome:

**Family History**

Has anyone in your family ever had a psychiatric diagnosis? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please indicate name(s) of the individual(s), diagnosis, and relation to you:

Does anyone in your family have a history of alcohol or drug problems? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please indicate who and describe the nature of their substance use or abuse:

Mother’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If deceased, date and cause of death:

Father’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If deceased, date and cause of death:

Please describe your mother’s personality and the nature of your relationship with her:

Please describe your father’s personality and the nature of your relationship with him:

Number of times married: Mother \_\_\_\_\_\_\_\_\_\_\_\_\_ Father \_\_\_\_\_\_\_\_\_\_\_\_\_

Names and ages of any siblings:

Please describe the nature of your relationship(s) with your siblings(s):

Is there any other important or relevant information that you would like to share?

*Thank you for completing this form!*

Signature of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_