CONFIDENTIAL INFORMATION SHEET

Today's Date: _____ Name: _____

Date of Birth: _____ Age_____ Social Security Number: _____

Marital status: (circle) Single Married Separated Divorced Cohabitating Widowed

Address: _____

_____

Telephone: (H) _____ (W) _____ (C) _____

Referred to this Office by: _____

Occupation: _____

Place of Employment or School: _____

Emergency Contact: _____ Home/cell # _____ Work # _____

Primary Care Physician: _____ Date of Last Physical: _____

Physician's Address & Phone Number: _____

Do You Take Prescribed Medications? Yes No Take Non-Prescription Drugs? Yes No
Take Supplements of Any Kind? Yes No Use Tobacco? Yes No
Drink Alcohol? Yes No

Current Problem(s): (circle) Anxiety, Depression, Drug/Alcohol, ADHD/ADD, Marital/Relationship, Panic, Impulse Control, Stress, Sexual Problem, Eating Disorder, Chronic Pain, Tension/Migraine Headaches, Child-Parent, Domestic Violence, Occupational, Sleep, Anger, Learning/Academic, Life Transition, Feel Persecuted, Strange Thoughts, Rituals, Obsessions, Memory Problem, Legal Problem, Other: _____

Your Estimate of the Problem:	None:	Mild	Moderate	Severe
Anxiety level	0	1 2 3	4 5 6	7 8 9
Sad/unhappy mood	0	1 2 3	4 5 6	7 8 9
Anger/irritability	0	1 2 3	4 5 6	7 8 9
Thoughts of Suicide	0	1 2 3	4 5 6	7 8 9
Thoughts of Hurting Someone	0	1 2 3	4 5 6	7 8 9
Stress level	0	1 2 3	4 5 6	7 8 9
Concentration Problem	0	1 2 3	4 5 6	7 8 9
Alcohol/drug/tobacco	0	1 2 3	4 5 6	7 8 9
Health Problems	0	1 2 3	4 5 6	7 8 9
Duration of Primary Problem	___ Weeks	___ Months	___ Years	

Previous Mental Health Treatment? Inpatient Yes No Dates: _____
Outpatient Yes No Dates: _____

Family History of Alcohol/Drug Problem? Yes No
Family History of Mental Health Problem? Yes No Family History of Mental Health Treatment? Yes No