Please check issues that you are dealing with currently.

___Alcohol Abuse	___Drug Abuse	___Other Addiction
___Sleep Problem	___Eating Disorder	___Body Image Concern
___Work Problems	___Financial Problems	___Sexual Problems
___Depression	___Anxiety	___Obsessive/Compulsive
___Domestic Violence	___History of abuse	___Anger Problems
___Relationship Problem	___Chronic Pain	___Physical Health Problem
___Grief/Loss	___Disability	___Legal Problems
___Family Planning	___Aging Parent	___Caregiver for disabled person
___Phobia	___Self Esteem	___Problem with child
___Suicidal thoughts	___Homicidal thoughts	___Self-mutilation

___Yes ___No Have you ever served in the military?
If so, branch and dates._____

___Yes ___No Would you like for your physician or other health care provider to receive information about your appointment and treatment? If so, please provide name and contact information for the provider to be notified.

_____
_____

Please check each statement below to which you can respond "yes".

___ In the past year have you ever drank or used drugs more than you intended to or spent more time drinking or using than you intended to?
___ In the past year have you ever neglected some of your usual responsibilities because of using alcohol or drugs?
___ In the past year have you believed you needed to "cut down" on your use of alcohol or drugs?
___ Has anyone objected to your use of alcohol or drugs?
___ Have you found yourself preoccupied with thoughts about using alcohol or drugs?
___ Have you used alcohol or drugs over the past year to relieve emotional discomfort such as sadness, anger, or boredom?

Current Medications: (please list)

_____
_____
_____
_____

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Psychiatric History:
(Please list any previous mental health or addiction treatment you have received including inpatient or outpatient treatment, names of providers, and dates of service.

If you have a family history of mental illness or addiction, please describe.

Medical History:
(Please list any relevant medical condition for which you are currently receiving treatment or have received treatment previously.)

Goals: (What would you like to accomplish by attending counseling at this time? Please be specific.)

Other: (Please describe any other information that you believe I should be aware of or that is relevant to your current reason for seeking treatment.)

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