





of death. \_\_\_\_\_  
\_\_\_\_\_

Describe your relationship with each of your siblings: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAMILY MEDICAL HISTORY:** Since many psychological difficulties may be influenced by family environment or genetics, please indicate any psychological, alcohol/drug, suicide attempts, or medical difficulties experienced by other members of your family:

Father \_\_\_\_\_

Mother \_\_\_\_\_

Siblings \_\_\_\_\_

Children \_\_\_\_\_

Aunts/Uncles \_\_\_\_\_

Grandparents \_\_\_\_\_

**REFERRAL INFORMATION**

Were you referred by someone?  Yes  No If yes, who? \_\_\_\_\_

Please indicate why you are requesting services and the type of difficulties you are experiencing.  
\_\_\_\_\_  
\_\_\_\_\_

When did your difficulties begin? \_\_\_\_\_

How serious do you consider your difficulties? \_\_\_\_\_  
\_\_\_\_\_

**MEDICAL HISTORY**

Name of Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Rate your general health:  Excellent  Very good  Good  Fair  Poor  Very poor

Do you have allergies?  Yes  No If yes, what? \_\_\_\_\_  
\_\_\_\_\_

Indicate any and all medications and dosages that you are now taking.

<u>Medication</u>	<u>Dose</u>	<u>Start Date</u>	<u>M.D. Prescribing</u>
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all current illnesses/conditions.

Illness/Condition \_\_\_\_\_ Treating M.D. \_\_\_\_\_ Treatment \_\_\_\_\_

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

Do you smoke/chew tobacco?  Yes  No If yes, amount/day \_\_\_\_\_

Do you drink alcohol?  Yes  No

If yes, how much? \_\_\_\_\_ How often? \_\_\_\_\_

Do you use illicit drugs or abuse medications?  Yes  No

If yes, which ones? \_\_\_\_\_

How much? \_\_\_\_\_ How often? \_\_\_\_\_

**PREVIOUS PSYCHOLOGICAL/PSYCHIATRIC TREATMENT**

**INPATIENT TREATMENT**

Hospital \_\_\_\_\_ Date \_\_\_\_\_ Reason \_\_\_\_\_ Outcome \_\_\_\_\_

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

**OUTPATIENT TREATMENT**

Therapist \_\_\_\_\_ Date \_\_\_\_\_ Reason \_\_\_\_\_ Outcome \_\_\_\_\_

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

**PREVIOUS MEDICATIONS**

Medication/Dose \_\_\_\_\_ Date \_\_\_\_\_ Response \_\_\_\_\_

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

If you have a religious preference, please indicate: \_\_\_\_\_

What are your hobbies/recreational pursuits? \_\_\_\_\_

Describe your personal/social support network. \_\_\_\_\_

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

In order to obtain a full and complete picture of all the things that may be of concern to you, please complete the following checklist.

CHECK any of the boxes of the following concerns that apply to you and rate its severity in the blank at the right, using the following scale:

- 1 = Mildly distressing
- 2 = Moderate
- 3 = Serious
- 4 = Severe
- 5 = Very severely distressing

Example:  Marital Stress 3

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Marital Stress___                            | <input type="checkbox"/> Feeling suicidal___                    | <input type="checkbox"/> Upset Stomach___                     |
| <input type="checkbox"/> Other Family Problems___                     | <input type="checkbox"/> Feeling worthless___                   | <input type="checkbox"/> Sweating ___                         |
| <input type="checkbox"/> Other Relationship Problems___               | <input type="checkbox"/> Lack of interest/enjoyment___          | <input type="checkbox"/> Lightheaded/Dizzy___                 |
| <input type="checkbox"/> Problems at work/school___                   | <input type="checkbox"/> Too Many Drugs___                      | <input type="checkbox"/> Too Much Worry___                    |
| <input type="checkbox"/> Health Problems___                           | <input type="checkbox"/> Too Much Alcohol___                    | <input type="checkbox"/> Too Many Fears___                    |
| <input type="checkbox"/> Financial Problems___                        | <input type="checkbox"/> Feel Negative About Future___          | <input type="checkbox"/> Feeling Guilty___                    |
| <input type="checkbox"/> Legal Problems___                            | <input type="checkbox"/> Hard to Make Friends___                | <input type="checkbox"/> Feeling Angry/Frustrated___          |
| <input type="checkbox"/> Sad/Depressed___                             | <input type="checkbox"/> Feeling Lonely___                      | <input type="checkbox"/> Nightmares___                        |
| <input type="checkbox"/> Loss of Appetite___                          | <input type="checkbox"/> Sexual Problems___                     | <input type="checkbox"/> Feel Ignored/Abandoned___            |
| <input type="checkbox"/> Loss of Weight___                            | <input type="checkbox"/> Less Energy than Usual___              | <input type="checkbox"/> Too Much Pain ___                    |
| <input type="checkbox"/> Gain of Weight___                            | <input type="checkbox"/> More Energy than Usual___              | <input type="checkbox"/> Confused___                          |
| <input type="checkbox"/> Difficulty sleeping___                       | <input type="checkbox"/> Very Talkative___                      | <input type="checkbox"/> Laugh without Reason___              |
| <input type="checkbox"/> Difficulty concentrating___                  | <input type="checkbox"/> Restless/Can't Sit Still___            | <input type="checkbox"/> Memory Problems___                   |
| <input type="checkbox"/> Quick Change of Moods___                     | <input type="checkbox"/> Nervous/Tense___                       | <input type="checkbox"/> See/Hear Strange Things___           |
| <input type="checkbox"/> Dwelling on Problems___                      | <input type="checkbox"/> Panicky___                             | <input type="checkbox"/> Hard to Trust Anyone___              |
| <input type="checkbox"/> Problems with Breathing___                   | <input type="checkbox"/> Shaky/Trembly___                       | <input type="checkbox"/> Hot or Cold Spells___                |
| <input type="checkbox"/> Problems Controlling<br>My Anger or Urges___ | <input type="checkbox"/> Feeling Others Are Out<br>to Get Me___ | <input type="checkbox"/> Watched/Talked About<br>By Others___ |
| <input type="checkbox"/> Problems Controlling<br>My Thoughts___       | <input type="checkbox"/> Other_____                             | <input type="checkbox"/> Other_____                           |

List any other comments or ideas you have that may be helpful to the course of your therapy:

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\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**CONSENT TO RECEIVE SERVICES**

This will acknowledge and certify that on the date noted below, I requested Employee Assistance Program services. I understand that a treatment program plan will be implemented to meet the goals which have been jointly developed by myself and my counselor/therapist.

I further understand that my records are confidential and are protected by law. In most cases, they may not be released without my prior written consent. I have been apprised that there are some limited exceptions to confidentiality including, but not limited to when (a) a life-threatening situation exists (suicide or homicide); (b) there is a strong suspicion of child abuse occurring in the home; (c) I am involved in a criminal proceeding as a defendant, victim or witness.

I further acknowledge that in order for me to achieve the treatment goals that I have chosen for myself, it will be my responsibility to actively participate in and cooperate with the treatment process. If I am not in agreement with any aspect of the process, I will bring it to the attention of my counselor/therapist. I understand that I am free to withdraw from treatment at any time.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Client/Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness