

PLEASE PRINT THESE PAGES AND ANSWER THE QUESTIONS

NOTE: Please read instructions provided with this form and follow directions carefully. You may skip any question that you consider too personal or if it does not relate to your situation. Please write on the back of any page if an answer does not fit in the boxes.

TODAY'S DATE						
YOUR NAME			BIRTH DATE		AGE	
WORK PHONE		HOME PHONE		INSURANCE		
ADDRESS			CITY		STATE	ZIP
YOUR DOCTOR			YOUR COUNSELOR			

CHIEF CONCERN: Please describe the major medical and emotional health concerns that you would like to discuss with the doctor/therapist.

HISTORY OF YOUR PRESENT CONCERNS: For each problem listed above describe, when the problems started, what made the problem worse or better. How often do the symptoms occur? What medications and treatments worked or did not work?

PAST EMOTIONAL HEALTH HISTORY: Please circle the words that describe your emotional status. You may write additional information on the back of any page.

DEPRESSED MOOD	Rarely	Sometimes	Often
IRRITABLE MOOD	Rarely	Sometimes	Often
EXTREME MOOD CHANGES	Rarely	Sometimes	Often: How often? _____ days / weeks / months
APPETITE	Down	Ok	Too much
SLEEP	Little	Ok	Too much
ENERGY	Low	Ok	Too much
FATIGUE	None	Sometimes	Often
CONCENTRATION	Unable	Ok	Too focused
NIGHTMARES	None	Sometimes	Often
SLEEP WALKING	None	Sometimes	Often
BED WETTING	None	Sometimes	Often
COMPULSIVITY	Rarely	Sometimes	Often
IMPULSIVITY	Rarely	Sometimes	Often
ANXIETY	Rarely	Sometimes	Often
EXCESSIVE WORRY	Never	Sometimes	Often
PANIC ATTACKS	None	Sometimes	Often
HEAR VOICES WHEN NO ONE IS AROUND	None	Sometimes	Often
TRAUMA	None	Past	Recent : Describe _____
PHYSICAL/SEXUAL ABUSE	None	Past	Recent : Describe _____
AGGRESSIVE FEELINGS	Rarely	Sometimes	Often : Describe _____
RECENT DEATH / LOSS	No	Yes	Who? _____ When? _____
SIGNIFICANT LIFE CHANGES	None	Past	Recent : describe _____
LEGAL PROBLEMS	No	Yes:Describe: _____	
PREVIOUS COUNSELING	No	Yes:Describe: _____	
PSYCHIATRIC HOSPITALIZATIONS	No	Yes:When? _____ Why? _____	
SUICIDAL THOUGHTS	Never	Sometimes	Often Describe: _____
SUICIDE ATTEMPTS	No	Yes:Describe: _____	
SELF-HARM BEHAVIOR	No	Yes:Describe: _____	

PAST MEDICAL HISTORY

Anemia	No	Yes	Year _____	Mononucleosis	No	Yes	Year _____
Arthritis	No	Yes	Year _____	Pneumonia	No	Yes	Year _____
Asthma	No	Yes	Year _____	Kidney problem	No	Yes	Year _____
Bleeding disorder	No	Yes	Year _____	Rheumatic fever	No	Yes	Year _____
Blood transfusion	No	Yes	Year _____	Sexual Infection	No	Yes	Year _____
Cancer	No	Yes	Year _____	Thyroid problem	No	Yes	Year _____
Diabetes	No	Yes	Year _____	Tuberculosis	No	Yes	Year _____
Heart or Blood Pressure Problem	No	Yes	Year _____	Tic disorder	No	Yes	Year _____
Hepatitis	No	Yes	Year _____	Ulcer	No	Yes	Year _____

Other _____

FRACTURES OR DISLOCATIONS : List broken bones, or dislocations.

_____ Date _____ Date _____ Date

SURGERIES: List all and Date:

HOSPITALIZATIONS: List all medical and psychiatric hospitalizations and/or serious illnesses & the date they occurred. Use back of this page if necessary.

LIST ANY MEDICATIONS TO WHICH YOU ARE ALLERGIC & Describe reaction

ARE YOU ALLERGIC TO LATEX RUBER? _Yes_No - What happens? _____

MEDICATIONS: DO YOU TAKE ANY OF THE FOLLOWING?

Aspirin, Tylenol	No	Yes		Water pills	No	Yes		Vitamins	No	Yes
Diet pills	No	Yes		Thyroid medicine	No	Yes		Supplements	No	Yes
Laxatives	No	Yes		Tranquilizers	No	Yes		Birth Control	No	Yes

OTHER MEDICATIONS YOU ARE TAKING OR HAVE TAKEN IN THE LAST 2-3 YEARS – LIST PROBLEMS / BENEFITS OF EACH MEDICATION ON BACK

DESCRIBE ANY ALTERNATIVE HEALTH CARE MEDICATIONS OR TREATMENT

IS IMMUNIZATION STATUS UP TO DATE? _Yes_No Hepatitis-A _Yes_No
 Hepatitis-B _Yes_No Meningitis _Yes_No Tetanus Toxoid __Yes_No

FAMILY HISTORY – write “D” beside name if deceased.

	Name	Present Age or Age at Death	<i>Depression</i>	<i>Bipolar disorder</i>	<i>Suicide</i>	<i>Drug use</i>	<i>Alcoholism</i>	<i>Panic, Anxiety, or OCD</i>	<i>Violent or Abusive</i>	<i>Schizophrenia</i>	<i>Psych Hospitalization</i>	<i>Allergies asthma</i>	<i>Bleeding disorder</i>	<i>Cancer</i>	<i>Diabetes</i>	<i>Heart trouble</i>	<i>High blood pressure</i>	<i>Seizures</i>	<i>Thyroid disorder</i>	<i>Ulcer</i>	<i>Other inherited diseases</i>		
Father																							
Mother																							
Step-Father																							
Step-Mother																							
Brothers																							
Brothers																							
Sisters																							
Sisters																							
Maternal uncles																							
Maternal aunts																							
Paternal uncles																							
Paternal aunts																							
Spouse #1																							
Spouse #2																							
Children																							
Maternal Grand Father																							
Maternal Grand Mother																							
Paternal Grand Father																							
Paternal Grand Mother																							

Describe your relationship with your biological parents, now and as a child.
Describe the relationship now and in the past with foster-or adopted parents.
Describe your relationships with your brothers and sisters.
If your parents separated or divorced, describe how old you were at the time of the first separation. _____ Years What impact did this separation have on your life?
Please circle the words that describe your early family experiences as: Warm / Caring / Fun / Cold / Distant / Scary / Frightening / Abusive/ Can't remember

DEVELOPMENTAL HISTORY

At birth, were you a normal 9-month vaginal delivery? _____ Yes _____ No If no, explain _____
Did you grow and develop normally the first 5 years: ___ Yes ___ No If no describe on back>>
When your mother was pregnant with you, did she take any medications or use alcohol, tobacco, DES, or other drugs? _ Yes _ No // If yes List _____

SCHOOL & EMPLOYMENT HISTORY

School Name		Grade Level You are in now	
Contact Person			
Grades GPA (Now/Last Year)	Now	Last Year	
Number of times changed schools			
Favorite subjects		Least favorite class	
Relationship with teachers/authority figures			
Relationship with peers at school			
Learning Disability or problems			
Any disciplinary actions			
Problems with fighting/ truancy/ gangs			
Extracurricular activities			
Involvement in school counseling			
Advanced/held back a grade			
Highest completed level of school?	Grade School, Jr Hi, High School, Trade school, College- 2yr 4 yr, Masters Degree, PHD, RN,		

What type of job/work do you do?	
Problems at work? Past or Present	
Legal Problems:	

PEER RELATIONSHIPS / PERSONAL IDENTITY / ACTIVITIES / SPORTS

Do you have a best friend or partner that you can share feelings with? _____ Yes _____ No	
Peer relationships	Describe:
Interests/Hobbies	
Spirituality/Religion	
Life goals	
Sports:	Prior: _____ Now: _____
Do you exercise regularly?	No Yes, Bike / Swim / Run / Stairmaster ___ minutes ___ x per week No Yes Lift weights ___ x week If bicycle/ skate-board, do you wear Helmet? Yes / No
Wear a seat belt?	Yes No Recommended

RISKS

Substance	First Use-Age	Dose /Amount	Frequency x/wk	Last Use - Date
Caffeine		Tea cups/day--Coffee cups/day --Pop cans/day		
Tobacco				
Alcohol				
Marijuana				
Stimulants				
Cocaine				
Opiates				
Sedatives				
Tranquilizers				
Inhalants				
Other Drugs				

REVIEW OF SYSTEMS

Do you have, or in the past year have you had any of the following? (circle yes or no). If you have the symptoms now, place a "N" for "NOW" near the Yes box.					
Acne	YES	NO		Problems sleeping	YES NO
Lumps, swelling	YES	NO		Weakness, fatigue	YES NO
Skin rash	YES	NO		Fevers	YES NO
Itching	YES	NO		Shaking chills	YES NO
Moles	YES	NO		Excessive sweating	YES NO
Moles change color or size	YES	NO		Sweating at night	YES NO
Headaches	YES	NO		Dizziness	YES NO
Head or neck injury-	YES	NO		Loss of consciousness Date _____	YES NO
Blurred or double vision	YES	NO		Seizures/convulsions Date _____	YES NO
Eye pain or redness	YES	NO		Ear pain	YES NO
Frequent bloody noses	YES	NO		ringing in the ears	YES NO
Frequent sore throats or cold	YES	NO		Sinus infection	YES NO
Cough	YES	NO		Chest pain/tightness	YES NO
Sputum/phlegm	YES	NO		Racing heart	YES NO
Coughing up blood	YES	NO		Irregular heart beat	YES NO
Wheezing/asthma	YES	NO		Ankle swelling	YES NO
Shortness of breath	YES	NO		Exercise intolerance	YES NO
Trouble swallowing	YES	NO		Yellow jaundice	YES NO
Heartburn/indigestion	YES	NO		Black stools	YES NO
Stomach pain	YES	NO		Rectal bleeding	YES NO
Nausea	YES	NO		Hemorrhoids	YES NO
Bloating	YES	NO		Weight gain (over 5 lbs)When _____	YES NO
Vomiting	YES	NO		Weight loss (over 5 lbs)When _____	YES NO
Constipation	YES	NO		Food intolerance Describe _____	YES NO
Diarrhea	YES	NO			
Burning on urination	YES	NO		Blood in urine	YES NO
Urinate often	YES	NO		Urinate at night	YES NO
Concern about sexual function	YES	NO		Growth problems	YES NO
Excessive thirst	YES	NO		Sensitivity to heat	YES NO
Excessive urination	YES	NO		Sensitivity to cold	YES NO

Joint pain	YES	NO		Joint stiffness	YES	NO
Joint swelling	YES	NO		Pain in muscles or tendons	YES	NO
Back pain or stiffness	YES	NO		Joint injury	YES	NO
Current Height _____ Weight _____			Highest Weight _____ Date _____			
Lowest Weight last 2 years _____			Date _____ Why did weight drop? _____			
Indicate with a check on the line how you feel about your height & weight:						
Underweight _____	Satisfied _____		Overweight _____			
Too short _____	Satisfied _____		Too tall _____			

MALE ONLY

Unusual discharge from penis	YES	NO		Pain in testicles	YES	NO
Concern re: sexual function	YES	NO		Other concerns	YES	NO

FEMALE ONLY

Last normal menstrual period Date		Previous normal menstrual period Date	
Age at first period		Menstrual cramps (circle one)	Mild, Moderate, Severe
Length of menstrual bleeding _____ Days		Period occurs	every _____ days
Menstrual flow(circle one)	Light, Medium, Heavy	Pelvic pain without period	Yes, No
Unusual discharge or itching from vagina	Yes, No		
Pregnancy _____, Abortion _____, Miscarriage _____			

MALE & FEMALE: Any other medical or psychological concerns – please describe. :

PLEASE RETURN THIS QUESTIONNAIRE TO OUR OFFICE BY FAX [206-202-1985] OR MAIL TO [P.O.Box 12257, Olympia WA 98508] .

PLEASE CONSULT YOUR REGULAR DOCTOR OR EMERGENCY ROOM IF YOU HAVE A CRISIS OR NEED CARE PRIOR TO YOUR FIRST APPOINTMENT IN OUR OFFICE.

THANK YOU