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 WHCH 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	Depression	Bipolar disorder	Suicide	Drug use	Alcoholism	Panic, Anxiety, or OCD	Violent or Abusive	Schizophrenia	Psych Hospitalization	Allergies asthma	Bleeding disorder	Cancer	Diabetes	Heart trouble	High blood pressure	Seizures	Thyroid disorder	Ulcer	Other inherited diseases
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 QUESTIONAIRE 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