Name: _____ Date: _____

GENERAL HISTORY QUESTIONNAIRE

Reason(s) for testing:

_____

_____

_____

_____

_____

_____

Is this evaluation part of a lawsuit or criminal charge? □ Yes □ No

- If yes: □ Lawsuit □ LPS/Conservatorship □ Criminal
- Evaluation arranged by:

  □ Dr. _____ □ Attorney □ Other side's attorney □ District Attorney □ Judge □ Other: _____

Was this evaluation recommended by a physician or other professional? □ Yes □ No

- If yes: □ Primary care: _____ □ Neurologist: _____ □ Pediatrician: _____

  □ Psychiatrist: _____ □ Psychologist/Therapist: _____

Is this evaluation/ referral a result of injury, accident, or illness? □ Yes □ No

- If yes, date of injury, accident, illness (when symptoms started): _____

Do you experience any memory problems? □ Yes □ No

If so, please check and/or circle to specify:

□ Difficulty recalling phone numbers, directions, people's names, what just happened

□ Difficulty recalling events that happened recently, news, assignments, appointments

□ Difficulty recalling your birthday, birthplace, childhood, historical events

□ Other: _____

Do you experience any speech/language problems? □ Yes □ No

If so, please check and/or circle to specify:

□ Finding words

□ Organizing thoughts and putting them into sentences

□ Clearly understanding what others are saying

□ Other: _____

Name: _____ Date: _____

Do you experience any attention/organizational problems? □ Yes □ No

If so, please check and/or circle to specify:

□ Had hard time paying attention even for short periods of time, very distractible, daydreaming, lost in own thoughts

□ Can concentrate for a while, but become distracted after a while, can't keep track of information for long periods of time

□ Hard time following lectures, following conversations

□ Hard time organizing thoughts, the tasks that need to be completed

□ Despite efforts, things are messy, lose things all the time, hard to find things needed to complete work

□ Hard to manage/concentrate

Please provide a brief summary of your main complaints. Describe how your problems began, the major problems you initially experienced and current problems you are experiencing:

_____

_____

_____

_____

_____

BACKGROUND HISTORY

Location of birth: _____ Location for majority of childhood: _____

Mother is: □ Living □ Deceased □ Unknown

- If living, her health is: □ Excellent □ Good/normal □ Fair □ Poor
- If deceased, year of death _____, age _____, cause _____

Father is: □ Living □ Deceased □ Unknown

- If living, her health is: □ Excellent □ Good/normal □ Fair □ Poor
- If deceased, year of death _____, age _____, cause _____

Including your current marriage, please list the total number of marriages:

Year of Marriage #1: _____ to _____ Now: □ Married □ Divorced □ Widowed

Year of Marriage #2: _____ to _____ Now: □ Married □ Divorced □ Widowed

Year of Marriage #3: _____ to _____ Now: □ Married □ Divorced □ Widowed

Do you have any children? □ Yes □ No If yes: Males (ages: _____) Females (ages: _____)

Do any of your children live with you? □ Yes □ No If yes, which ones? _____

Do any of your children have health problems? □Yes □ No If yes, please specify: _____

Name: _____ Date: _____

Including all natural siblings, living or not living, please describe the number of siblings growing up.

____ Brothers ____ Half-brothers ____ Step-brothers

____ Sisters ____ Half-sisters ____ Step-sisters

Were you the: □ Only child □ Oldest □ Youngest □ Middle □ Other: _____

Did any of your siblings have serious health problems? □ Yes □ No

If yes, please explain: _____

Did any of your siblings have serious learning problems? □ Yes □ No

If yes, please explain: _____

DEVELOPMENTAL HISTORY
Prenatal Information

To the best of your knowledge, while pregnant with you, was your mother:

□ A smoker? □ Drug user? □ Alcohol user/abuser? □ Physically abused/victim of domestic violence?

□ Diagnosed with a psychiatric illness? (e.g. depression, anxiety, bipolar disorder, etc.) If so, please specify: _____

Please elaborate on any items above that were checked: _____

_____

To the best of your knowledge, did your mother have to take any medication(s) during the pregnancy? □ Yes □ No

If yes, please specify: _____

To the best of your knowledge, while pregnant with you, did your mother experience any:

□ Injuries? □ Illnesses? □ Fainting spells? □ Bleeding? □ Anemia?

□ Hospitalizations? □ Surgeries? □ Abdominal impact? □ Other conditions: _____

Please elaborate on any items above that were checked: _____

_____

Delivery and Early Childhood Information

To the best of your knowledge, the pregnancy was: □ Full term □Premature If premature, by how many months? _____

To the best of your knowledge, the labor was: □ Normal □ Abnormal Was there: □ Use forceps? □ Fetal distress?

Was medication given during delivery? □ Yes □ No

To the best of your knowledge, the delivery was: □ Routine □ Caesarian □ Breech □ Other:_____

Apgar (if known): _____ Weight at birth: _____lbs _____oz Please explain: _____

Were there complications such as: □ Cyanosis? □ Jaundice? □ Limpness? □ Congenital defects? □ Hypoxia □ Other

If so, please elaborate: _____

Was there a need for the following: □ Oxygen? □ Transfusions? □ Tube feedings? □ Unusually long hospital stay?

If so, please elaborate: _____

Name: _____ Date: _____

Were you breastfed? □ Yes □ No If yes, until how old? _____

Were you bottlefed? □ Yes □ No If Yes, until how old? _____

Were there difficulties with feeding? □ Yes □ No Sucking? □ Yes □ No Swallowing? □ Yes □ No

If so, please elaborate: _____

During infancy, were you: (may check all that apply)

□ Slow to calm? □ Fussy, irritable, or colicky? □ Alert? □ Passive?

□ Fussy eater? □ Non-demanding? □ Quiet? □ Active?

During infancy, sleep patterns could be best described as: □ Regular □ Irregular

If irregular, please describe: _____

Please add additional information regarding infancy that was not inquired in the space below: _____

_____

At what age did you: Roll over both ways? _____ □ DK Crawl? _____ □ DK Sit alone? _____ □ DK

Walk? _____ □ DK Speak 1st word? _____ □ DK 1st sentence? _____ □ DK Drink independently?____ □ DK

Feed self? _____ □ DK Take first steps? _____ □ DK Walk independently? _____ □ DK Dress by self? ____ □ DK

Use spoon independently? _____ □ DK Put on shirt independently? _____ □ DK Button independently? _____ □ DK

Developmental Milestones Guide: Normal Attainment Ages
Motor: Held head up: 1mo Sat up: 7-10mos Stood up: 1yr Walked: 1.5yrs Ran, climbed stairs: 2yrs
Talk: Vocalized 6mos Vocalized to Name: 7-11mos 1 Word: 11-12mos 2-Word Sent: 1-2yrs Complete sentence: 2-3yrs
Toilet: Day urination control: 2.5yrs Night urination control + Bowel Control: 4 yrs

At what age were you: daytime toilet trained? _____ □ DK nighttime toilet trained? _____ □ DK

Have you been diagnosed with enuresis? □ Yes □ No If yes, please elaborate: _____

Early Childhood Information

Please provide dates of illness for the following, or mark N/A:

	Date:	N/A		Date:	N/A		Date:	N/A
Lung Problems			Mumps			Heart Trouble		
Meningitis			Measles			Excessive Vomiting		
Chicken Pox			Diabetes			Tuberculosis		
High Fevers			Allergies			Seizures		
Scarlet Fever			Polio			If so, how often? _____		
Whooping Cough			Ear Infection(s)					
			Did treatment require inner ear tubes? □ Yes □ No					

Please provide additional information: _____

_____

Name: _____ Date: _____

As a child, were there any physical injuries or surgical procedures? ☐ Yes ☐ No

If yes, please describe: _____

Aside from the aforementioned physical injuries/surgeries, have there been any other incidents requiring hospitalization? ☐ Yes ☐No

If so, please provide: date: _____ incident information: _____

date: _____ incident information: _____

As a child, were there any incident(s) of: ☐ Head trauma? ☐ Loss of consciousness? ☐ Concussion? ☐ Exposure to toxins?

☐ Impact to head (sports, falls, accidents)? ☐ Suffocation/accidental drowning?

If so, please provide: Date:_____ Incident information: _____

Date:_____ Incident information: _____

As a child, were you:

Physically abused? ☐Yes ☐No ☐ Possibly Please explain: _____

Emotionally abused? ☐Yes ☐No ☐ Possibly Please explain: _____

Mentally abused? ☐Yes ☐No ☐ Possibly Please explain: _____

Sexually abused? ☐Yes ☐No ☐ Possibly Please explain: _____

Neglected? ☐Yes ☐No ☐ Possibly Please explain: _____

During childhood, were there major stresses/problems in the home? ☐ Yes ☐ No

If yes, please indicate: ☐ broken home ☐ death of parent ☐ serious illness ☐ substance use ☐ other: _____

Please provide more information: _____

SOCIAL HISTORY

As a child/adolescent, were you considered: ☐ "Different"? ☐ Introverted? ☐ Hostile/aggressive? ☐ Extroverted/outgoing

☐In the "in" group/popular ☐"Dancing to beat of your own drum"?

Did you have a normal social life? ☐ Yes ☐ No

Did you have a normal number of friends? ☐ Yes ☐ No

Please provide additional information:_____

EDUCATIONAL HISTORY

How many years of formal education have you received? _____ High School Diploma = 12, AA=14, BA/BS=16, MA/MS=18, Ph.D/MD/Ed.D=20

Please check highest level of degree attained: ☐ HS Diploma/GED ☐ AA/AS ☐ BA/BS ☐ MA/MS ☐ Ph.D/MD/JD

Typical grades in college/high school: _____ Grade Point Average in college/high school: _____

Please list the most recent three schools attended:

dates: _____ to _____ School: _____ Graduated? ☐ Yes Mo/Yr:_____ ☐No Degree: _____

dates: _____ to _____ School: _____ Graduated? ☐ Yes Mo/Yr:_____ ☐No Degree: _____

dates: _____ to _____ School: _____ Graduated? ☐ Yes Mo/Yr:_____ ☐No Degree: _____

Name: _____ Date: _____

Have you ever been held back/repeat a grade: ☐ Yes ☐ No If yes, what grade(s)? _____

Please specify reason(s) for being held back: _____

Have you ever been told you had any of the following:

A learning disorder? ☐ Yes ☐ No If Yes: ☐ Reading ☐ Spelling ☐ Writing ☐ Math ☐ Other

Attention Deficit Disorder? ☐ Yes ☐ No If Yes: ☐ ADD ☐ ADHD Age at diagnosis: _____

Who tested you/made the diagnosis? ☐ Teacher ☐ Counselor ☐ Psychologist ☐ Other _____

What were your best/easiest/favorite subject(s) in school? _____

What were your worst/hardest/least favorite subject(s) in school? _____

EMPLOYMENT HISTORY

Are you currently: ☐ Employed ☐ Employed, on leave ☐ Retired ☐ On disability

☐ Unemployed ☐ Student ☐ Homemaker ☐ On SSI/SSD

What is your most current job title/description? _____

How long have you worked in this capacity? _____ When did you last work? _____

If unemployed, why did you leave? ☐ Laid Off ☐ Moved ☐ Quit ☐ Fired ☐ Retired ☐ Worker's compensation

Please list your current and prior jobs, most recent first:

Dates: _____ Employer: _____

Job duties/title:_____ Avg hrs/wk: _____ Why you left: _____

Dates: _____ Employer: _____

Job duties/title:_____ Avg hrs/wk: _____ Why you left: _____

Dates: _____ Employer: _____

Job duties/title:_____ Avg hrs/wk: _____ Why you left: _____

Dates: _____ Employer: _____

Job duties/title:_____ Avg hrs/wk: _____ Why you left: _____

Have you ever been in the military? ☐ Yes ☐ No If yes, complete below:

Branch? _____ MOS: _____ From: _____ To _____

Discharge type: ☐ Honorable ☐ General ☐ Medical/Mental Highest Rank _____ Lost Rank? ☐ Yes ☐ No

Where did you serve? _____

Do you have a service connected disability? ☐ Yes ☐ No If yes, please elaborate:

%_____ for _____ %_____ for _____

%_____ for _____ %_____ for _____

Add other information you feel it is important for us to know: _____ _____

_____

Name: _____ Date: _____

LEGAL HISTORY

Have you ever been arrested? □ Yes □ No If yes, please complete below. Please indicate frequency and/or date:

Assault_____ Robbery_____ Burglary_____ Disturbing the Peace_____

Drug Possession/Sales_____ Forgery_____ Homicide_____ Spousal Abuse _____

Auto Theft_____ Fraud_____ DUI _____ Sexual Offense_____

Details: _____

Excluding any current and/or ongoing lawsuit, have you ever been engaged in a lawsuit claim:

Personal Injury? □ Yes □ No Harassment? □ Yes □ No Unlawful Termination? □ Yes □ No

Please give details about when (what year), what the lawsuit was about, who was involved in the suit, and what the outcome of each lawsuit was: _____

_____

DRIVING HISTORY

Do you have a valid driver's license? □ Yes □ No Ever lost license or had it suspended? □ Yes □ No If yes, due to:

□ Speeding □ DUI □ Too many tickets □ Seizures □ No insurance □ Other: _____

Did you drive here today? □ Yes □ No Are you currently unable to drive? □ Yes □ No

How many motor vehicle (car, truck, motorcycle) accidents have you been involved in the last 10 years?

<circle> none 1-2 3-4 5+ How many were your fault? <circle> none 1-2 3-4 5+

MEDICAL HISTORY

Current height is: _____ ft _____in Current weight: _____lbs Ideal weight: _____lbs

During the past 3-6 months, weight has □ Increased _____lbs □ Decreased _____lbs □ Stayed the same

Weight change mainly due to: □ Illness □ Diet Change □ Less/more Exercise □ Don't Know

Sleep

Sleeping pattern:

- □ Most nights I sleep well
- □ Difficulty getting to sleep
- □ Difficulty staying asleep
- □ Awaken too early, cannot get back to sleep
- □ Snoring
- □ Pauses in breathing
- □ Frequent bad dreams or repeating dreams about: _____

Sleeping problems began_____

Name: _____ Date: _____

In order to sleep, do you: ☐ Take pills? ☐ Drink alcohol? ☐ Take a bath? ☐ Meditate? ☐ Other_____

Do you have sleep apnea? ☐ Yes ☐ No Use CPAP Machine? ☐ Yes ☐ No ☐ Not anymore If yes, since_____

Do you suffer from frequent and/or extreme headaches (i.e. so bad that a prescription was given)? ☐ Yes ☐ No

If yes, headaches are currently: ☐ Mild ☐ Moderate ☐ Severe

Headaches occur: ☐ Many times daily ☐ Once a day ☐ Once/several times per week ☐ Several times per month

When did these headaches begin? _____ What caused them? _____

Were there long periods without headaches? ☐ Yes ☐ No

What seems to start or prolong the headache? ☐ Nothing ☐ Bright/flashing lights ☐ Certain foods ☐ Loud Noise

☐ Certain Drinks ☐ Stress/worry ☐ Cold air ☐ Other: _____

What seems to reduce or stop the headache? ☐ Nothing ☐ Alcohol ☐ Rest/relaxation

☐ Coffee/tea ☐ Medication: _____ ☐ Herbal medicine: _____

Has there been any change in sensation? ☐ Yes ☐ No If yes, please indicate areas of numbness/reduced sensation:

Left: ☐ Entire left side *Or Only*: ☐ Shoulder ☐ Face ☐ Hand ☐ Upper body ☐ Leg ☐ Foot/toes

Right: ☐ Entire right side *Or Only*: ☐ Shoulder ☐ Face ☐ Hand ☐ Upper body ☐ Leg ☐ Foot/toes

Has there been any change in taste/smell? ☐ No ☐ Yes, please indicate: ☐ Taste ☐ Smell ☐ Both taste and smell

Since when? ☐ Can't say ☐ Date: Month/Year: _____ ☐ Accident: _____ ☐ Illness: _____

☐ Mold ☐ Chemicals: _____ ☐ Other substances: _____

Do you have a history of stroke or "CVA"? ☐ Yes ☐ No If yes, please complete below:

Date: _____ Type (if you know): ☐ Hemorrhage ☐ Aneurysm ☐ Embolism ☐ Thrombosis ☐ Ischemia

☐ AV Malformation What, if any, was your weak side? ☐ Left ☐ Right

Date: _____ Type (if you know): ☐ Hemorrhage ☐ Aneurysm ☐ Embolism ☐ Thrombosis ☐ Ischemia

☐ AV Malformation What, if any, was your weak side? ☐ Left ☐ Right

Please provide additional information if possible: _____

Do you have a history of brain infection/brain related disease? ☐ Yes ☐ No If yes, please complete below:

Date: _____ Type (if known): ☐ Meningitis ☐ HIV ☐ Lupus ☐ Herpes ☐ Encephalitis ☐ Brain cyst ☐ Other

Date: _____ Type (if known): ☐ Meningitis ☐ HIV ☐ Lupus ☐ Herpes ☐ Encephalitis ☐ Brain cyst ☐ Other

Please provide additional information if possible: _____

Is there a history of: [please circle to specify]	**Patient**	**A Family Member (circle)**
Chronic Fatigue Syndrome	Yes No	Sister Brother Parent Grandparent Child
Fibromyalgia	Yes No	Sister Brother Parent Grandparent Child
Back/Neck/Spine Problems	Yes No	Sister Brother Parent Grandparent Child
Vision Problems: ☐corrective lenses ☐no corrective lenses	Yes No	Sister Brother Parent Grandparent Child

Name: _____ Date: _____

Hearing Problems: □hearing aid □no hearing aid	Yes No	Sister Brother Parent Grandparent Child
Allergies [Pollen, dust, cats, foods, milk, drugs]	Yes No	Sister Brother Parent Grandparent Child
Bladder Disease [Chronic infection]	Yes No	Sister Brother Parent Grandparent Child
Cancer [Breast, Ovarian (women), Prostate (men)]	Yes No	Sister Brother Parent Grandparent Child
Diabetes [High blood sugar]	Yes No	Sister Brother Parent Grandparent Child
Eating Disorder [Anorexia Nervosa, Bulimia]	Yes No	Sister Brother Parent Grandparent Child
Epileptic Fits or Seizures	Yes No	Sister Brother Parent Grandparent Child
Erectile Dysfunction [Impotence; Men] Sexual Arousal Disorder [Women]	Yes No	Sister Brother Parent Grandparent Child
HIV Positive Blood Test/AIDS	Yes No	Sister Brother Parent Grandparent Child
Kidney Disease [Kidney stones, kidney failure]	Yes No	Sister Brother Parent Grandparent Child
Liver Disease [Cirrhosis, Hepatitis, Jaundice]	Yes No	Sister Brother Parent Grandparent Child
Lyme Disease [Bitten by a deer tick]	Yes No	Sister Brother Parent Grandparent Child
Osteoporosis [Loss of bone density with age]	Yes No	Sister Brother Parent Grandparent Child
Thyroid Disease [Hypo=low; Hyper=high]	Yes No	Sister Brother Parent Grandparent Child
Heart Problems [Heart attack, Abnormal rhythm, Mitral valve, Pacemaker, Bypass, Angioplasty, Cholesterol]	Yes No	Sister Brother Parent Grandparent Child
Stomach/Intestinal [Ulcers, Gastritis, Acid reflux, Chrohn's Disease, Colon cancer, Irritable bowel, Chronic diarrhea]	Yes No	Sister Brother Parent Grandparent Child
Blood Pressure [High, Low, Fainting Spells, Dizzy/Light-Headed]	Yes No	Sister Brother Parent Grandparent Child
Cognitive Disorder [Delirium, Dementia, Alzheimer's, Amnestic]	Yes No	Sister Brother Parent Grandparent Child
Disorders with genetic predisposition [Parkinson's, Huntington's, etc]	Yes No	Sister Brother Parent Grandparent Child

Please list all the drugs/medicines you are now taking, including prescription and non-prescription drugs (i.e. cold remedies, antacids, Aspirin, Tylenol, etc., herbal supplements, homeopathic remedies):

Medication: _____ Dose (if known): _____/day Since: _____ For:_____

Medication: _____ Dose (if known): _____/day Since: _____ For:_____

Medication: _____ Dose (if known): _____/day Since: _____ For:_____

Medication: _____ Dose (if known): _____/day Since: _____ For:_____

Medication: _____ Dose (if known): _____/day Since: _____ For:_____

Medication: _____ Dose (if known): _____/day Since: _____ For:_____

Please list any unpleasant side effects for these medications (i.e. dry mouth, drowsiness, insomnia, etc.)

Medication: _____ Side effects: _____

Medication: _____ Side effects: _____

Medication: _____ Side effects: _____

Medication: _____ Side effects: _____

Name: _____ Date: _____

Have you ever had surgical procedures? □ Yes □ No If yes, please complete below, starting with the most recent:

Date:_____ Type of surgery:_____ Hospital: _____

Date:_____ Type of surgery:_____ Hospital: _____

Date:_____ Type of surgery:_____ Hospital: _____

Please provide additional information regarding surgical procedures if needed: _____

_____

Have you ever had a brain study? □ Yes □ No If yes, please check all that apply:

□Electroencephalogram (EEG) □Computed Tomography (CT) scan □Position Emission Tomographic (PET) scan

□Magnetic Resonance Imaging (MRI/fMRI) scan □Brain Electrical Activity Mapping (BEAM)

□Single Photon Emission Computed Tomography (SPECT) scan □Other: _____

If known, please indicate what the abnormal study showed: _____

_____

Have you ever had a head injury? ? □ Yes □ No If yes, please complete the following:

By "head injury," we mean an injury in which: a) the patient either hit his/her head on something, b) something hit the patient in the head, or c) the patient experienced such a severe whiplash that the patient was dazed, confused, or unconscious.

Date:_____ Cause: □ Car accident □ Fall □ Fight □ Bullet/Shrapnel □ Surgery □ Other: _____

Lose consciousness? □ Yes □ No If yes, how long were you unconscious for? Please indicate below:

5-60sec	1-5min	5-10min	10-20min	30-60min	1-2hr	2-8hr	8-24hr	1-2days	2-6days	7-14days	2-4weeks	>4wks

Please provide additional information about the head injury below: _____

_____

Nutrition

Please tell us about your diet: _____

_____

Amount of artificial sweeteners/diet drinks: _____

Please provide additional information about medical history that was not inquired in the space below:

_____

_____

MENTAL HEALTH HISTORY

Please check the statement that best applies:

□ I have never been evaluated or treated for a mental or emotional problem

□ I have been evaluated, but never treated, for a mental or emotional problem

Why? _____ When? _____

Name: _____ Date: _____

Who did the evaluation? _____

☐I have been treated for a mental or emotional problem for the first time at the age of _____ for:

☐ Depression ☐ PTSD ☐ Bipolar/Mania ☐ Trouble with the law

☐ Anxiety ☐ Schizophrenia ☐ School problems ☐ Marital problems

☐ Parent/sibling problems ☐ Work problems ☐ Other: _____

When? (estimate year) _____ Where? _____

Who provided treatment? _____ Outcome: ☐ No change ☐ Some improv. ☐ Signif. Improve.

Type of treatment: ☐ Individual (1-to-1) ☐ Couples ☐ Family ☐ Group

Was medication prescribed? ☐ Yes ☐ No If so, please list:

Dates: _____ Prescription: _____ For: _____ Effective? ☐ Yes ☐ No

Dates: _____ Prescription: _____ For: _____ Effective? ☐ Yes ☐ No

Frequency of appointments: ☐ 2x per week ☐ Weekly ☐ Every 2 weeks ☐ 3-4x per month ☐ Irregular appts

Later treatment(s): estimate the year, identify the main problem(s), and the treatment provider

Year: _____ Problems: _____ Provider: _____

Year: _____ Problems: _____ Provider: _____

Year: _____ Problems: _____ Provider: _____

Are you currently in treatment for a mental health problem? ☐ Yes ☐ No If yes, please complete below:

Name of treatment provider: _____ Total visits to date (approx): _____

Frequency of appointments: ☐ 2x per week ☐ Weekly ☐ Every 2 weeks ☐ 3-4x per month ☐ Irregular appts

Type of treatment: ☐ Individual (1-to-1) ☐ Couples ☐ Family ☐ Group

Was medication prescribed? ☐ Yes ☐ No If so, please list:

Dates: _____ Prescription: _____ For: _____ Effective? ☐ Yes ☐ No

Dates: _____ Prescription: _____ For: _____ Effective? ☐ Yes ☐ No

Have you seriously thought about, planned, or attempted suicide? ☐ None ☐ Ideation ☐ Plan ☐ Attempt

Reasons:_____

Please list plans or attempts:

Year: _____ Method: _____ ☐ Plan ☐ Attempt

Year: _____ Method: _____ ☐ Plan ☐ Attempt

Year: _____ Method: _____ ☐ Plan ☐ Attempt

Do you currently find yourself thinking very angry thoughts, or feeling very angry toward a certain person? ☐ Yes ☐ No

If so, please check all that applies: ☐ Spouse ☐ Ex-husband/wife

☐ Neighbor ☐ Parent ☐ Coworker

☐ Boss ☐ Child ☐ Other: _____

Please elaborate: _____

Name: _____ Date: _____

Do you own and/or have access to firearms (pistol, rifle, shotgun)? □ Yes □ No If yes, please complete below:

Type: _____ Had for: _____ Used for: _____

Location: □ Home □ Work □ Car □ Other: _____ Locked? □ Yes □ No

SUBSTANCE USE HISTORY

Have you ever been a regular drinker of alcohol? □ Yes □ No If yes, please complete applicable section below:

Have you ever been a regular user of street drugs? □ Yes □ No If yes, please complete applicable section below:

Alcohol use history

If you drink now, how much do you usually drink? (please include drink of choice and quantity)_____

Frequency: □ Very rarely or never □ 1-2 times per month □ About once a week

□ 2-5 times per week □ About every day □ Wine with meals

□ Several drinks per day □ Drink until drunk □ Feel as if alcohol is a problem

If you drank in the past, how much did you usually drink? _____

_____

Has alcohol use ever caused a problem in the following areas? □ Marriage □ Work □ Family □ Work/School

□ Medical Conditions (such as cirrhosis, peripheral neuropathy, seizures) □ DUI If so, please elaborate:

Please provide details (when, where, how, frequency, etc.): _____

_____

Have you ever been in a treatment program for alcohol problems? □ Yes □ No

If yes, please provide details (when, where, duration of stay, etc.):_____

_____

Substance use history

Please choose the description that currently fits best:

□ I am not a regular user of any recreational drugs now, but at a younger age I experimented with drugs

□ I now use marijuana rarely, but not other drugs such as cocaine, heroin, speed, methamphetamines

□ I now use marijuana more than 4 times a month

□ I use one or more drugs at least once a week

□ I am a regular to heavy drug user

□ I feel I have a drug problem

□ I am addicted to one or more drugs [including cocaine, heroin, speed, methamphetamines]: please check all that apply below

□ Marijuana □ Cocaine/crack □ Heroin □ Opium □ Methamphetamine or speed □ Ecstasy

□ LSD □ Acid Prescription drugs: □ Vicodin □ Oxycontin □ Phenobarbital □ Demerol □ Dilaudid

Name: _____ Date: _____

Other: _____

Solvents/chemicals: □ Glue □ Gasoline □ Paint thinner □ Nitrous Oxide □ Other: _____

Was your drug use ever a problem in the following areas: □ Relationship □ Work □ Military □ School □ Legal

If so, please provide details (when, where, how, frequency, etc.): _____

Have you ever been in a treatment program for drug problems? □ Yes □ No

If yes, please provide details (when, where, duration of stay, etc.):_____

_____

Other Substance Use

Are you a cigarette/cigar smoker? □ No, never smoked □No, I quit in _____ □Yes, I smoke _____ per day

How long have you smoked for? _____ Have you had any health problems due to smoking? _____

Are you trying to cut down or quit? □ Yes □ No □ Eventually

Do you use caffeine? □ Yes □ No

If yes, how much do you use per day? _____ In what form?_____

Name: _____ Date: _____

Continuation page

You may add anything that you feel is important about your present condition, or use this page to explain previous items more completely. Thank you.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature Date

Note: If you are completing this form for the patient, please sign and date below:

_____

Print name

_____ _____

Signature of Person Completing Form Date

_____

Relationship to Patient