Chief concern: Please describe the main difficulty that has brought you to see me:

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Prior Treatment

1. Have you ever received psychological or counseling services before? No Yes If yes:

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<th>When?</th>
<th>From whom?</th>
<th>For what?</th>
<th>With what results?</th>
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2. Have you ever taken medications for psychiatric or emotional problems? No Yes If yes, please list medications taken and briefly describe the results:

___________________________________________________________________________________
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Abuse history: If you’ve ever been physically, emotionally, or sexually abused, please describe briefly:

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
Present relationships

1. How do you get along with your present spouse or partner?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

2. How do you get along with your children and/or your parents?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Chemical use

1. How much beer, wine, or liquor do you consume in an average week? ______________________
2. How much tobacco do you smoke or chew each week? _________________________________
3. Which drugs (not medications prescribed for you) have you used in the last 10 years? ______
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Please provide details about your use of these drugs or other chemicals, such as amounts, how often you
used them, and their effects:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Other

Is there anything else that is important for me as your therapist to know about, and that you have not
written about on this form? If yes, please tell me about it here:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.