

PATIENT INFORMATION

PATIENT NAME: _____ **DOB:** _____

Name of children (including step-children), please indicate their age and sex of each child: _____

How (or whom) referred you here _____

Have you ever received treatment for alcohol or drug abuse? YES NO

If yes, please indicate the place(s) and date(s): _____

Have you ever received Mental Health Treatment or counseling: YES NO

If yes, please indicate the date(s) and reason(s) for your: _____

In what ways did/didn't you find your treatment helpful? _____

Has anyone else in your family(i.e., spouse, children, parents, siblings, extended family) ever experienced a mental health or substance abuse problem? YES NO

If yes, briefly describe: _____

Please describe your reason and your goals for seeking our services at this time: _____

PAIN MANAGEMENT:

Do you have any physical pain? YES NO

If yes, please name the physician who is caring for this pain: _____

Where is the pain located (please be specific): _____

Are you on any pain medications? YES NO

If yes, please list the medications & dosages: _____

On a scale of one to ten, how severe is your pain? 1 2 3 4 5 6 7 8 9 10