

OTHER FAMILY MEMBERS	Living L	Deceased D	Lives With You?		Age	Quality of the Relationship
			Y	N		
Mother:			<input type="checkbox"/>	<input type="checkbox"/>		
Father:			<input type="checkbox"/>	<input type="checkbox"/>		
Step-Mother:			<input type="checkbox"/>	<input type="checkbox"/>		
Step-Father:			<input type="checkbox"/>	<input type="checkbox"/>		
Siblings:						
			<input type="checkbox"/>	<input type="checkbox"/>		
			<input type="checkbox"/>	<input type="checkbox"/>		
			<input type="checkbox"/>	<input type="checkbox"/>		
			<input type="checkbox"/>	<input type="checkbox"/>		
Grandparents:						
			<input type="checkbox"/>	<input type="checkbox"/>		
			<input type="checkbox"/>	<input type="checkbox"/>		
			<input type="checkbox"/>	<input type="checkbox"/>		
			<input type="checkbox"/>	<input type="checkbox"/>		
Others (Specify):						
			<input type="checkbox"/>	<input type="checkbox"/>		
			<input type="checkbox"/>	<input type="checkbox"/>		
			<input type="checkbox"/>	<input type="checkbox"/>		

Do any family members have a history of emotional or alcohol/substance abuse problems and/or treatment? Yes No
 If yes, please provide details. _____

Please list all prior mental health and alcohol/substance abuse counseling or treatments that you have received.

Where: _____ When: _____
 Where: _____ When: _____
 Where: _____ When: _____
 Where: _____ When: _____
 Where: _____ When: _____

Have you ever experienced any academic or behavioral difficulties during any time in school? Yes No
 If yes, please describe your difficulties. _____

Have you ever been in trouble with the law? Yes No
 If yes, please detail the circumstances. _____

MEDICAL HISTORY	→ PLEASE USE THIS AREA FOR ADDITIONAL CATEGORY INFORMATION:
Weight and Height:	
Current Weight (pounds):	
Maximum Adult Weight :	
Minimum Adult Weight :	
Height:	
HEALTH PROBLEMS:	
Yes <input type="checkbox"/> No <input type="checkbox"/> (If Yes, Please List)	
Past	Present
ALLERGIES:	
Yes <input type="checkbox"/> No <input type="checkbox"/> (If Yes, Please List)	
Substance:	Reaction:
SLEEPING DIFFICULTIES:	
Difficulty with daily functioning <input type="checkbox"/>	
Falling asleep <input type="checkbox"/>	
Falling back to sleep <input type="checkbox"/>	
Tired upon waking <input type="checkbox"/>	
Early morning awakening <input type="checkbox"/>	
Bad dreams <input type="checkbox"/>	
Nightmares <input type="checkbox"/>	
Wetting the bed <input type="checkbox"/>	
Walking in sleep <input type="checkbox"/>	
Snoring <input type="checkbox"/>	
Stop breathing during sleep <input type="checkbox"/>	
Falling asleep when emotional <input type="checkbox"/>	
SMOKING:	
Yes <input type="checkbox"/> No <input type="checkbox"/> (If Yes, Please List)	
Packs per day:	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> Other <input type="checkbox"/>
Age you began:	_____

ALCOHOL USE:	
Do you drink? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please check your average daily consumption (ounces): 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Other <input type="checkbox"/>	<hr/> <hr/>
Were you ever told or felt that you should cut down on drinking? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Have you ever felt bad or guilty about your drinking? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you ever drink first thing in the morning to steady your nerves or get rid of a hangover (an eye-opener)? Yes <input type="checkbox"/> No <input type="checkbox"/>	
DRUG USE:	
Do you use drugs? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Drugs Used: Marijuana <input type="checkbox"/> Cocaine/Crack <input type="checkbox"/> Amphetamines <input type="checkbox"/> Heroin/Opiates <input type="checkbox"/> PCP <input type="checkbox"/> LSD/Hallucinogens <input type="checkbox"/> Barbiturates/Sedatives <input type="checkbox"/> Over the Counter <input type="checkbox"/>	<hr/> <hr/> <hr/>
RANGE OF DAILY ACTIVITIES (done on a regular basis):	
Exercising <input type="checkbox"/> Seeing Friends <input type="checkbox"/> Reading <input type="checkbox"/> Hobbies <input type="checkbox"/> Using the telephone <input type="checkbox"/> Going to clubs <input type="checkbox"/> Preparing meals for family/self <input type="checkbox"/> Caring for children/others <input type="checkbox"/>	
SOCIAL/LEISURE ACTIVITIES/HOBBIES (Please list below): →	(If you wish to include information about activities, do so below.)
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THANK YOU FOR YOUR TIME AND COOPERATION.