IATTAR-C, LTD

INSTITUTE FOR ADDICTION TREATMENT, TRAINING & RESEARCH-CARIBBEAN, LTD

■CLINICAL ■PSYCHOMETRICS ■ADDICTION & SUBSTANCE ABUSE ■EAP ■FORENSIC ■PSYCHOLOGICAL SERVICES

INSTRUCTIONS:

THE INFORMATION IN THIS SURVEY WILL BE HELD IN THE STRICTEST OF PROFESSIONAL CONFIDENCE. *To help us serve you better, please answer the following questions about your background and current situation. We are looking for precise details, so you should answer the questions quickly and briefly. Some of the questions may not apply to you and so should be skipped. Please do not spend a long time on any one question. However, if you need more space, please feel free to use the back of the page. If you cannot remember some detail requested, please make a reasonable estimate. If you are unsure how to answer a question, or if you wish to discuss your answer with your therapist, please note this in the margin. We will not release this information to anyone without your written permission. Moreover, we will not seek information about you from other sources (such as your family physician, pediatrician, etc.) without your written permission, except in the case of an emergency. There is no need to fill in the ID # unless you have been told to do so. Thank you for your help!☺*

Name:_____ **[TRN]SSN #:**____/____/_____

Today's Date:_____ **What Name Do You Prefer To Be Called:**_____

Age:_____ **DOB:**___/__/_____ **Se**

☐**Male** --☐**Female** **Other:** _____

Ethnic Background (Race):_____ **What Is Your Height?**_____

Please Describe Your Weight? _____

Please Describe Your Residence?

☐**A House** ☐**A Hotel** ☐**A Room** ☐**An Apartment** ☐**Boarding Home** ☐**Foster Home**
☐**Detention Facility** ☐**Hospital** ☐**Other**

Home #: (___) _____ **Cell phone #(s):** _____

Work Telephone: [_____] _____ **Other #/s:** _____

E-mail Address (es): _____

Address: [City/State/Zip Code]

Is It OK for Us To Leave You A Message At Home Or To Send You E-mail Messages?

Yes --☐**No** _____

Your Occupation? _____ **How Long?**_____
Name of Employer:_____
Address of Employer:_____
Employer's PH#?_____ **Work PH#:**_____

SOCIAL AND FAMILY HISTORY:

Current Living / Household Arrangements:

☐☐**Alone** ☐**With My Spouse** ☐**With Spouse and Children** ☐**With Both Natural Parents**
☐**With Roommates** ☐**With Mother** ☐**With Father** ☐**Other Relative**
☐**Non-Relative Home** ☐**Significant Other** ☐**Other:**_____

Significant Relationship Status:

☐**Married** ☐**Single** ☐**Engaged** ☐**Separated** ☐**Divorced** ☐**Remarried**
☐**Committed Relationship** ☐**Widowed** ☐**Other:**

Name Of Person With Whom You Reside [live]:_____

Their Phone #: [___] _____

Address: [City/State/Zip Code]:

Their Work Telephone: [_____] _____

Other Telephone #(s):[_____] _____

Significant Other's Name: _____

Their Age:_____ **Occupation:**_____

Significant Other's Employer: _____

How Long Have They Worked Here?_____

How Long Have You Been With Your Spouse/Partner? _____

Will Your Partner/Spouse Want To Attend Some Sessions With You? -☐**Yes** --☐**No**

Please Explain:

Work E-Mail: _____

Please Describe The Reason(s) For Your Making This Appointment [*Your Presenting Concerns, Signs & Symptoms*] Below:

Please List The Names And Ages Of All Children (Including Step-Children) Who Currently Live In The Same Household With You:

NAME:	AGE:

Do You Know What Started This/ These Issue(s)?
-☐Yes --☐No
-Describe:

What are your goals for receiving therapy?

PPRESENTING PROBLEM/CURRENT ISSUES:
[Please describe what is happening that lead to your visit today?]

Mental Health Screening [MHS-III] Form-III:

Instructions: In this program, we help people with all their problems, not just their addic
This commitment includes helping people with emotional problems.
staff is ready to help you to deal with any emotional problems you may have,
m but we can do this only if we are aware of the problems. Any information you provide to us on this form will be kept in strict confidence. It will not be released to any outside person or agency without your permission. If you do not know how answer these questions, ask the staff member giving you this form for guidance.

MHS III-CONTINUED

11. Have you ever experienced any emotional problems associated with your sexual interests your sexual activities, or your choice of sexual partner?
--☐Yes --☐No

12. Was there ever a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, forcing yourself to throw up?
--☐Yes –☐No

Please note, each item refers to your entire life history, not just your current situation, this is why each question begins "Have you ever."

1. Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem?
--☐Yes –☐No
2. Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems?
--☐Yes --☐No
3. Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem?
--☐Yes --☐No
4. Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons?
--☐Yes --☐No
5. Have you ever heard voices no one else could hear or seen objects or things which others could not see?
--☐Yes --☐No
6. (a) Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself?
--☐Yes --☐No
(b) Did you ever attempt to kill yourself?
--☐Yes --☐No
7. Have you ever had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot alternatively, stabbed?
--☐Yes --☐No
8. Have you ever experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help?
--☐Yes --☐No
9. Have you ever given in to an aggressive urge or impulse, on more than one occasion , which resulted in serious harm to others or led to the destruction of property?
--☐Yes --☐No
10. Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts
or behavior?
--☐Yes --☐No
13. Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything?
--☐Yes --☐No
14. Have you ever had spells or attacks when you suddenly felt anxious, frightened, and uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint?
--☐Yes --☐No
15. Have you ever had a persistent, lasting thought or impulse to do something repeatedly that caused you considerable distress and interfered with normal routines, work, or your social relations? *Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and re-washing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate (change).*
--☐Yes --☐No
16. Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling?
--☐Yes --☐No
17. Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem?
--☐Yes –☐No

CLINICIAN USE ONLY: CLIENT DO NOT COMPLETE!

Total Score: _____(each yes = 1 point)

Source: J.F.X. Carroll, Ph.D., and John J. McGinley, Ph.D.; Project Return Foundation, Inc., 2000. This material may be reproduced or copied, in entirety, without permission.
www.asapnys.org/Resources/mhscreen.pdf

Please Indicate Which of the Following Signs and Symptoms Apply to You Now—Or have Applied In The Past 3-6 Months?

☐Headaches	☐Palpitations	☐Bowel Disturbance	☐Anger	☐Feeling Tense
☐Feeling Depressed	☐Unable To Relax	☐Disliking Weekends	☐Disliking Holidays	☐Nightmares
☐Disliking Vacations	☐Unable To Keep a Job	☐Financial Problems	☐Excessive Sweating	☐Dizziness

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☐Stomach Trouble ☐Fatigue ☐Taking Sedatives ☐Feeling Panicky ☐Conflict ☐Marital Problems
☐Suicidal Ideas ☐Sexual Problems ☐Over Ambitious ☐Feelings of Inferiority
☐Loneliness ☐Memory Problems ☐Often Uses Aspirins ☐Often Using Painkillers ☐Fainting Spells
☐Anxiety ☐Lack of Appetite ☐Insomnia ☐Use of Alcohol ☐Tremors
☐Taking of Drugs ☐Allergies ☐Excessively Shy Around People ☐Bad Home Conditions
☐Difficulty With Concentration ☐Unable To Have A Good Time ☐Difficulty Making Decisions
☐Difficulty Making Friends ☐Other Problem(s)? Please Describe::

Please Rate The Severity Of The Above Signs and Symptoms {Please Check [√] a Box to Describe *How Bad These symptoms are For You*}.

☐Mildly Upsetting ☐Moderately Upsetting ☐Totally Incapacitating
☐Very Severe ☐Extremely Upsetting

Which Of The Following Words, Terms Or Concepts Apply To, Or Describe You?

☐Worthless	☐Useless	☐Nobody	☐Life is Empty	☐Inadequate	☐Stupid	☐Incompetent
☐Naïve	☐Guilty	☐Evil	☐Morally Wrong	☐Hostile	☐Full of Love	☐Full of Hate
☐Anxious	☐Agitated	☐Cowardly	☐Unassertive	☐Panicky	☐Aggressive	☐Ugly
☐Deformed	☐Unattractive	☐Repulsive	☐Depressed	☐Lonely	☐Unloved	☐Misunderstood
☐Bored	☐Restless	☐Confused	☐Unconfident	☐In Conflict	☐Full of Regrets	☐Worthwhile
☐Can't Do Anything Right		☐Horrible Thoughts		☐Sympathetic	☐Intelligent	☐Considerate
☐Attractive		☐Confident				

Please List Additional Words:

Primary Health Care Provider Name: _____
Address of Your Doctor/ Healthcare Provider:

I give my therapist permission to consult with my health care provider regarding my health and treatment.

Comments:

Doctor's PH#: _____ Fax: _____ Your Initials _____ Date: _____
Did Your Insurance Company Refer You To Us? --☐Yes --☐No _____
Do You Have The Number And/ Or Name Of The Person That You Called To Find Us Through Your Insurance Company? -☐Yes -☐No-
Please List the Number/s:

Were You Referred To Us By Someone Else, Such As Your Physician, Attorney, Our Signage, etc.? --☐Yes --☐No

SELF-HARMING BEHAVIORS & HISTORY:
Have Any Of Your Family Members Ever Committed Or Attempted Suicide?
-☐Yes --☐No --☐N/A –Please Describe:

Please Describe The Telephone Directory Listing That You Found Us Under?
☐Psychologists ☐Marriage And Family Therapists ☐Counselors ☐Other Listing
(Please Describe):

SELF-DESCRIPTON AND PERCEPTION
***Please Complete The Following Statements By Writing Your First Thought Upon Reading The Sentence}*:**

I Am A Person Who?

All My Life?

Ever Since, I Was A Child?

One of The Things I Feel Proud Of Is?

It Is Hard For Me To Admit?

One Of The Things That I Cannot Forgive Is?

One of The Things That I Feel Guilty About Is?

If I Didn't Have To Worry About My Image?

Have You Ever Thought About Suicide (Killing Yourself)?
-☐Yes --☐No –☐N/A
Please Describe:

In Your Whole Life, Have You Ever Had a Specific Plan For How You Would Kill Yourself? -
Yes --☐No --☐N/A
-Please Describe:

Have You Ever, in Your Whole Life, Tried to Kill Yourself?
-☐Yes --☐No --☐N/A
–Describe:

How Many Times Have You Tried To Kill Yourself?
☐Once ☐Twice ☐Three Times ☐Four Times ☐Five, or More Times -☐Never

Please Describe the Time/s You Attempted Suicide

How Old Were You When You First Tried To Kill Yourself?
☐Ten Years & Younger ☐Between Eleven & Fifteen Years Old
☐I Have Never Tried To Kill Myself ☐More Than Sixteen Years Old
-Please Describe:

Did You Get Any Medical Treatment After The Most Recent (Last) Time That You Tried To Kill Yourself? --☐Yes --☐No --☐N/A
–Describe:

Should You Have Had Medical Treatment Then, Even If You Did Not Get It?
--☐Yes --☐No --☐N/A
–-please Describe:

One Of The Ways That People Hurt Me Is?

Did You Get Medical Treatment Any of The Times When You Tried To Kill Yourself?
--☐Yes --☐No --☐N/A
–Please Describe:

Mother Was Always?

What I Needed From My Father, But Did Not Get Was?

What I Needed From My Mother And Didn't Get Was?

If I Weren't Afraid To Be Myself, I Might?

One Of The Things That I Am Angry About Is?

Father Was Always?

What I Need And Have Never Received From A Woman (Man) Is?

The Bad Thing About Growing Up Is?

Please Describe Your Most Irrational Thought, Or Idea?

One Of The Bad Things I Could Help About Myself, But Don't, Is?

Please Describe Any Relationship(s) That You Have With Other People That Makes You Feel Good?

What Sensations (Smells, Tastes, etc.) Make You Feel Good?

Please Describe Any Relationship(s) Makes You Feel Sad/ Grief?

What Sensations Make You Feel Bad?

How Would Your Best Friend Describe You?

Describe A Very Unpleasant Image (Color, Thought, Smell, etc.), Or Fantasy.

How Would Someone Who Dislikes You Describe You?

How Do You Describe Yourself?

How Would Your Spouse (If Married)/ or Partner, Describe You?

DEMOGRAPHICS:

Mother's Name:

Age: _____

Home Phone: [ ] _____

Cell Phone: [ ] _____

How Long Has/Did Your Mother Worked Here?

How old was your Mother when you were born? _____

Did your Parents plan their pregnancy with you?? -☐No -☐Yes -☐Not sure -☐Unknown

Does your Mother support you? –☐Regularly -☐Occasionally -☐Not at all

Does your Mother rent, lease, or own her present home? –☐Lease -☐Rent -☐Own -☐Not known

Is your Mother in some other kind of living arrangement? -☐No -☐Yes -☐Unknown

Which of the Following Describes Your Experience/s During Your Childhood/ Adolescence?

☐Night Terrors ☐Thumb Sucking ☐Finger Sucking ☐Fears ☐Bedwetting
☐Nail Biting ☐Happy Childhood ☐Sleepwalking ☐Stuttering

Work Phone: [ ] _____

E-Mail: _____

Mother's Occupation: _____

Mother's Employer: _____

CHILDHOOD & ADOLESCENCE HEALTH& BE HAVIOR:

Did You Have Any Physical Health Problems During Your Childhood? --☐Yes --☐No --If Yes, Please Describe?

Did You Have Any Major Childhood Illnesses --☐Yes --☐No -If Yes, Please Describe?

Describe this living arrangement:

What is your Mother's financial status? -☐Good -☐Not-so-good -☐Poor

Is your Mother deceased? -☐No -☐Yes -☐Not sure -☐Unknown

Date of death?

Cause of death [If known]? _____

How many siblings [brothers and sister] does your Mother have? _____

Position among siblings [first, 2nd, etc.]: _____

Who raised your Mother?
-☐Both parents -☐Mother alone -☐Father alone -☐Grandmother -☐Grandfather
-☐Another relative -☐A guardian
-☐An institution -☐Other
-Please Describe:

Was your Mother a victim of abuse as a child? -☐No -☐Yes -☐Unknown -☐Attempted

Describe the type of abuse: -☐Physical -☐Emotional -☐Sexual

What is your Mother's highest level of education?
-☐Primary school -☐All-age school --☐Secondary school -☐High school
-☐Technical school -☐Some college -☐Associates degree -☐Bachelor's degree
-☐Master's degree -☐Doctoral degree -☐Other -☐Unknown

Name and location of most recent school attended by your Mother:

Total number of children for your Mother? _____

Total number of fathers for the children? _____

Mother's marital status?
☐Married -☐Single -☐Divorced -☐Common-law -☐Visiting -☐Separated -☐Other
☐Unknown

What Was Your Health Like During Adolescence// Teenage Years?

Please Describe What Your Childhood and Adolescence Was Like [*Home Atmosphere, Parental Relationships]:*

Do You Recall Having Any Surgical Operations As a Child or Adolescent?
-☐Yes --☐No --If Yes, Please Describe?

(*List and give your age at the time that they were performed*):

Do You Remember If You Had Any Accidents As a Child/Teenager?
☐Yes -☐No --If Yes, Please Describe?

As Far As You Know, Did Anyone In Your Family Experience Significant Events, Such
Death, Abuse (physical, emotional, sexual) Divorce, Separation, Other

Major Life Problems) In Your Childhood? -☐Yes -☐No
If Yes, Please Describe?

During Your Childhood/ Teenage Years Were You Treated For Any Mental or Emotion
Problem[s]?
-☐Yes --☐No

Number of years married? _____

Number of years in current relationship? _____

Length of longest relationship? _____

Does your Mother have a family history of:
-☐Diabetes -☐Asthma -☐Mental problems -☐Learning problems
-☐ Drugs or Alcohol Issues
-☐Other/ Unknown _____

Stepparents /Guardian's Name: _____

Age: _____

Home Phone: [ ] _____

Cell Phone: [ ] _____

Work Phone: [ ] _____

E-Mail: _____

Occupation: _____

How Long? _____

Father's Employer: _____

Does your Father rent, lease, or own his present home?
☐Lease -☐Rent -☐Own -☐Not known
How Did/ Does your Guardian/ father/mother support you as a child?

–☐Regularly -☐Occasionally -☐Not at all

Does your Guardian/Stepparent rent, lease, or own their present home? ☐Lease -☐Rent

-☐Own -☐Not known

Are your Stepparents/ Guardians in some other kind of living arrangement?

-☐No -☐Yes -☐Unknown

-
\-If Yes, Please Describe?

Father's Name: _____

Age: _____

Home Phone: [ ] _____

Cell Phone: [ ] _____

Work Phone: [ ] _____

E-Mail: _____

Occupation: _____

Employer: _____

How Long? _____

How old was your father when you were born? _____

Was this child's pregnancy planned? -☐No -☐Yes -☐Not sure -☐Unknown

Did/ does your the father support you?
–☐Regularly -☐Occasionally -☐Not at all

Is your Father in some other kind of living arrangement?
-☐No -☐Yes -☐Unknown Please, Describe this living arrangement:

What is your Father's financial status? -☐Good -☐Not-so-good -☐Poor

Is your Father deceased? -☐No -☐Yes -☐Not sure -☐Unknown

Date of death? _____

Cause of death [if known]? _____

How many siblings does your Father have? _____

Please, Describe this living arrangement:

Position among siblings? _____

Who raised your Father? -☐Both parents -☐Mother alone -☐Father alone -☐Grandmother -☐Grandfather -☐Another relative -☐A guardian -☐An institution -☐Other

Please, Describe:

What is your Guardian/ Stepparents' financial status?
-☐Good -☐Not-so-good -☐Poor

Has a previous Guardian/Stepparent died? -☐No -☐Yes -☐Not sure -☐Unknown

Date of death? _____

Cause of death [if known]:

How many siblings does the stepparent/Guardian have? _____

Position among siblings: _____

Who raised your Guardian/Stepparent?
-☐Both parents -☐Mother alone -☐Father alone -☐Grandmother -☐Grandfather -☐Another relative -☐A guardian -☐An institution -☐Other -Describe:

As Far as You Know, Was your Father a victim of abuse as a child?
-☐No -☐Yes -☐Unknown -☐Attempted

Please describe the type of abuse: -☐Physical -☐Emotional -☐Sexual

Was your Guardian/ Stepparent a victim of abuse as a child?
-☐No -☐Yes -☐Unknown -☐Attempted

Describe the type of abuse: -☐Physical -☐Emotional -☐Sexual:

What is your Stepparents'/ Guardians' highest level of education?
-☐Primary school -☐All-age school -☐Secondary school -☐High school

What is your Guardian/ Stepparents' highest level of education? -☐Primary school ☐All-age school -☐Secondary school -☐High school -☐Technical school -☐Some college -☐Associates degree -☐Bachelor's degree -☐Master's degree -☐Doctoral degree -☐Other -☐Unknown

Name and location of most recent school attended by your Stepparent/ Guardian:

What is your Father's highest level of education?
☐Primary school -☐All-age school -☐Secondary school -☐High school ☐Technical school -☐Some college -☐Associates degree ☐Bachelor's degree -☐Master's degree -☐Doctoral degree -☐Other ☐Unknown

Name and location of most recent school attended by your Father:

Total number of children for your Father? _____

Total number of mothers for the children? _____

Father's current/ most recent marital status?
-☐Married -☐Single -☐Divorced -☐Common-law -☐Visiting -☐Separated -☐Other -☐Unknown

Total number of children for your Stepparent/ Guardian?

Total number of mothers for the children? _____

Number of years married? _____

Length of longest relationship? _____

Is There Anything Else That You Want To Share With Your Therapist About Your Feelings Towards Your Stepparents/Guardians?
--☐Yes --☐No --☐Prefer not to say

Has Any of Your Family Members Been Treated For, Drugs, Alcohol, Gambling Or Other Emotional Problems?

-☐Yes -☐No --If Yes, Describe_____

Is There A History Of Mental Illness In Your Family: --☐Yes --☐No –
-Describe?

Is There A History Of Physical Abuse In Your Family? --☐Yes --☐No –

-Please Describe:

Number of years married [Father]? _____

Number of years in current relationship? _____

Length of longest relationship? _____

Does your Father have a family history of:
-☐Diabetes -☐Asthma -☐Mental problems -☐Learning problems
-☐ Drugs or Alcohol Issues -☐Other/ Unknown _____

Total number of fathers for the children?

Stepparent/Guardian's marital status?
-☐Married -☐Single -☐Divorced -☐Common-law -☐Visiting -☐Separated Other -☐Unknown

Number of years in current relationship?

On The Following Table, Please List Your Siblings By Age. And Describe Your Relationships With Them. (Both Past and Present):

NAME OF SIBLING:	AGE (DOB) / FAMILY PLACEMENT IN RELATIONSHIP TO CLIENT:	HOW DID YOU USE TO GET ALONG WITH THIS BROTHER/ SISTER?	HOW DO YOU GET ALONG WITH THIS SIBLING NOW?

Has Any One in Your Family Been A Victim of Sexual Abuse? --☐Yes --☐No –
–Describe:

Is There A History Of Domestic Violence In Your Family? --☐Yes --☐No –

FAMILY AND MEDICAL HISTORY:

Please give age, lists of any illness, or if deceased. If deceased, list cause of death and age of death

Mother:

Father:

Siblings:

Mother's parents:

Father's parents:

Does the Stepparent/Guardian have a family history of:---------->
-☐Diabetes -☐Asthma -☐Mental problems -☐Learning problems
-☐ Drugs or Alcohol Issues -☐Other/ Unknown _____

When Did You First Become Aware Of Your Own Sexual Needs and Desires?

Did You Ever Experience Any Anxieties Or Guilty Feelings Because of Sexual Experiences, Thoughts, Or Activities? ---☐Yes ---☐No

Please Describe:

How Were You Disciplined As A Child?

Who Disciplined You As A Child? _____

How Did You React?

DIETARY HISTORY:

Were you breastfed, --☐Yes ---☐No -and if so, until what age? _____

Were you fed formula as a baby? --☐Yes ---☐No

Please list any other childhood illnesses and the age at which they occurred:

Did you experience ear infections as a child? --☐Yes ---☐No

Use of antibiotics as a child/adult? --☐Yes ---☐No

Acne as an adolescent? --☐Yes ---☐No

Did/ Have You Experienced The Use of antibiotics as a ☐child/ ☐adult? --☐Yes ---☐No

Acne as an adolescent? --☐Yes ---☐No ---☐Nonex ☐Mild ☐Moderate ☐Severe

Please list any other childhood illnesses and the age at which they occurred:

Until age:

Please list any digestive complaints you recall having as a child (for example, stomach pains, diarrhea, constipation, gas, etc.)

Please list any other physical complaints you recall as a child (for example, fatigue, headaches, pain):

History of fasting? --☐Yes ---☐No -Please Discuss:

Do/Did You Feel Loved And Respected By Your Parents?
-☐Yes -☐ No—
-Please Describe:

As A Child -Or Now- Were/ Are You Able To Confide In Your Parents?
-☐ Yes --☐ No –
--Please Describe:

CURRENT DIETARY HABITS:

Please list any specific diets that you are currently following, for example, vegan diet (no dairy, meat, fish or eggs), vegetarian, Atkins, paleo, DASH, raw, GAPS, etc.

Eating Behaviors: Briefly describe your mealtime and snack patterns:

Food Allergies and Sensitivities:

Dairy sensitivity:

Did you experience any eating disorders during adolescence? --☐Yes ---☐No

MOTIVATION FOR NUTRITIONAL CHANGE

Please, Identify 3 Reasons to improve Your Diet

Please, Identify 3 Goals to Improve Your Diet

3 Months	*6 Months*	*12 Months*

Please Identify 3 Goals for Improving Your Food Preparation

3 Months	*6 Months*	*12 Months*

SEXUAL EXPERIENCES AND SEXUAL IDENTITY:

Please Describe Your Parent(s)/Guardian's Attitude Towards Sexuality Education:

Food Allergies and Sensitivities:

-☐ Wheat allergy -☐ Dairy allergy
-☐ Wheat sensitivity -☐ ☐Dairy allergy
-☐ Other

Please list any other known or suspected food allergies and sensitivities:

Are there foods you could not give up? If so, which ones?

Current Food Preparation Methods

Who's doing the shopping? -☐You - ☐Family member ☐Friend ☐Other
Do you eat with people or alone? -☐People ☐Alone
Do You Eat Out? -☐Yes -☐No

If so, how often?

What kinds of places do you eat out?

Do you prepare your own food? --☐Yes ---☐No
Do you enjoy cooking? --☐Yes ---☐No

How much time do you spend preparing food each day?
☐Never ☐1 hour 2 hours ☐3 hour

Did Your Parents Discuss Sex in the Home With You and Your Siblings As Children?
--☐Yes ---☐No
Please Describe:

Which Parent/Guardian Was Responsible/ Interested in Discussing Sex with You as a Child/ Teen?

When And How Did You First Learn About Sex?

Please Discuss Other Details About Your Sexual Needs/ History That May Assist Your Clinician In Understanding Where You Are Coming From, Your Treatment Issues, Or Clinical Needs [*Were you raped, sexually abused, do you have unusual sexual needs/ desires, problems, etc.*]

Do/ Did Your Parents Understand You? --☐Yes --☐No –
-Please Describe:

Is Your Present Sex Life As Satisfactory? -☐Yes -☐No Please Elaborate:

Food Symptoms [Please circle [√]any of the following food symptoms that you experi on a regular basis]:

Burping --☐Yes ---☐No		**Flatulence -☐Yes ---☐No**	
Bloating --☐Yes ---☐No		**Itching -☐Yes --☐No**	
Flushing--☐Yes ---☐No		**Stomachache -☐Yes --☐No**	
Sinus -☐Yes ---☐No		**Fatigue -☐Yes -☐No**	

Please, briefly describe your family's eating habits and meal times (Did you eat as a family? Did you eat at the table or in front of the television? Did you fend for yourself? Were foods prepared from packages? Was there fighting at mealtime?):

MEANING OF FOOD

Please describe in a few sentences what food means to you. There may be both positive and negative associations. There is no right or wrong to this answer. For example, is food important to you? Are you preoccupied with it? Does it feel nourishing? Does food cause fear or discomfort?

Please Check [√]the Box Which Describes Your Sexual Interests, Behaviors, Activities, and Attractions in the Past[*This is relevant, and important, so please answer even if you did not act on the feeling/ desire]:*

☐Only Males ☐Mostly Males ☐Only Females ☐Mostly Females
☐Equally Males and Females ☐Prefer not to say

To what degree do you consider yourself heterosexual [Attracted to members of the opposite sex?] Please place an "X" on the line as it best describes your sexual activ and preferences.

Please, circle or place an "X" on the area/s of this continuum that best describes your own sexual activities, preferences and desires, etc.	**Rating** | *Description* **0** | *Exclusively heterosexual* **1** | *Predominantly heterosexual, only incidentally homosexual* **2** | *Predominantly heterosexual, but more homosexual* **3** | *Equally heterosexual and homosexual* **4** | *Predominantly homosexual, but more than incidentally heterosexual* **5** | *Predominantly homosexual, only incidentally heterosexual* **6** | *Exclusively homosexual* **X** | *No socio-sexual contacts or reactions*

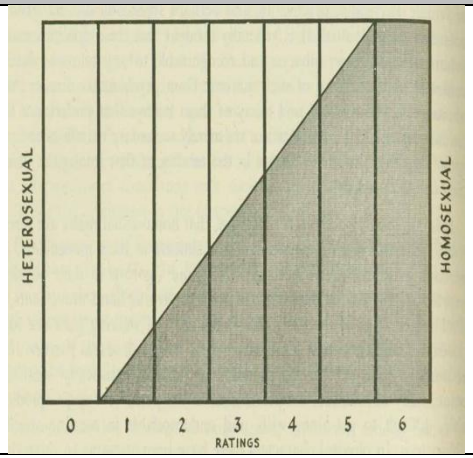
How Many Sexual Partners Have You Had in the Past Five Years? _____

Do You Always Use Protection When You Have Sex? --☐Yes --☐No

Do You Use Protection With Every Sexual Partner? --☐Yes --☐No

Have You Always Used Protection When Having Sex? --☐Yes --☐No

Who in Your Sexual Relationships is Responsible for Making Sure that Protection is Used?
-☐You? -☐The Partner -☐Both? -☐Other?



Please Circle Where Your Own Sexual Feelings, Experiences, Fantasies, Fall NOW On The Following Number Line (Continuum):

Heterosexual Attractions
[*How much I am sexually attracted to women- if I am male, or males- if I am a woman]*

←——————————Absent——————————→
Low High
[1 2 3 4 5 [0] 6 7 8 9 10]

Heterosexual Behavior
(*How much I do—or have done sexual things with members of the opposite sex/gender*)

←——————————Absent——————————→
Low High
[1 2 3 4 5 [0] 6 7 8 9 10]

Homosexual Attractions
(*How much I am sexually attracted to people of my own sex/gender]*

←——————————Absent——————————→
Low High
[1 2 3 4 5 [0] 6 7 8 9 10]

Do You Know How Your Parent(s)/Guardian's Felt About Talking To You About Sexuality/ Sex?
-☐Yes-- ☐No

Do/ Did You Parents Talk To You About Sex?
-☐Yes-- ☐No-
-Please Describe:

When And How Did You First Learn About Sex?

Do You Know How You Feel About Sex Now? --☐Yes ----☐No—Please Describe:

How Old Were You When You Became Aware Of Your Interest In Sex? _____
How Old Were You When You Lost Your Virginity? _____
How Did You Lose Your Virginity?

Homosexual Behavior
(*How much I do—or have done sexual things with men -if I am a male- or females- if I am a woman*

←————————————Absent————————————→

Low High

[1 2 3 4 5 [0] 6 7 8 9 10]

Do You Ever Feel Uncomfortable Or Guilty Because Of Your Sexual Experiences, Thoughts Interests?
Please Describe:

SEXUAL SELF-IDENTITY [*How Do You Label Yourself Sexually?*]:

☐**Heterosexual (Straight)** ☐**Homosexual (Gay/ Lesbian)**
☐**Bisexual** ☐**Prefer not to say** ☐**Uncertain** ☐ **Other:** _____

SEXUAL PRESENTATION [*How Do You Present Yourself Sexually to Other People*]

☐**Heterosexual (Straight)** ☐**Homosexual (Gay/ Lesbian)**
☐**Bisexual** ☐**Prefer not to say** ☐**Uncertain**
☐**Other (Please discuss)**

Before You Were Old Enough To Legally Give Permission, Did You Have Sexual Activ
With Anyone Who Was Older Than You? --☐Yes ---☐No
-Please Describe:

SOCIAL SEXUAL PERCEPTION
***[How Do Other People Describe (See) You Sexually]*:**
As Far As You Know, How Do Other People Perceive And /Or Describe Your Sexuality As? [In other words, people think, or say that you are?]:

☐**Heterosexual (Straight)** ☐**Homosexual (Gay/ Lesbian)**
☐**Bisexual** ☐**Prefer not to say** ☐**Uncertain**
☐**Other :**

Everyone Thinks About Sex -What Kinds Of Thoughts About Sex (Fantasies) Do You Have?

What Do You Think About When You Are Masturbating?

How Old Were You When You Started To Masturbate? _____

How Often Do You Masturbate? _____

What Was Your First Sexual Experience(s) Like?

Now, Please Circle Where on the Number Line [Continuum] Your Sexual Feelings Experiences, Fantasies Fell in the PAST:

Heterosexual Attractions
[*How much I am sexually attracted to women- if I am male, or males- if I am a woman]*

←——————————Absent——————————→

Low High

[1 2 3 4 5 [0] 6 7 8 9 10]

Heterosexual Behavior
(*How much I do—or have done sexual things with members of the opposite sex/gender*)

←——————————Absent——————————→

Low High

[1 2 3 4 5 [0] 6 7 8 9 10]

Homosexual Attractions
(*How much I am sexually attracted to people of my own sex/gender]*

←——————————Absent——————————→

Low High

[1 2 3 4 5 [0] 6 7 8 9 10]

Homosexual Behavior
(*How much I do—or have done sexual things with men -if I am a male- or females- if I am a woman]*

←——————————Absent——————————→

Low High

[1 2 3 4 5 [0] 6 7 8 9 10]

Has Anyone Ever Made You Have Sexual Contact That You Did Not Want, By Threat, Physical Force, Or Threatening The Use Of Force Against You, Your Pet, Or Against Someone/ Something That You Cared About?
--☐Yes -☐No
-Please Describe:

Have You Had Sexual Intercourse Or Contact With Anyone That Was Younger Than Y
--☐Yes -☐No- -
-Please Describe:

Have You Had Sexual Intercourse or Contact With Anyone That Was Older Than You Any Age?
-☐Yes -☐No
-Please Describe:

Have You Ever Made Anyone Have Sexual Contact With You That They Stated They D Not Want, By Using Threat, Physical Force, Or Threat Of Using Force Against Them C Someone/Thing That They Cared About?
-☐Yes -☐No
-Please Describe:

Do You Believe That You Are Currently Sexually Inhibited In Any Way? [*Are there sexual things you will not do now?*]
--☐Yes ---☐No
-Please Discuss:

RELIGIOUS VALUES & SPIRITUALITY:

How strong are your religious beliefs? [*Circle (◙) on the number line below*]

◄——————————————►

0 5 10

[Weak] [Moderate] [Strong]

Do you believe in a god or a power greater than yourself? -□Yes -□No

Religious/ Spiritual Identification:

How Has Religion Affected Your Life?

Do Your Religious Belief(s) And Or Spiritual Practices Impact On Your Life Presently?
☐Yes --☐No—
(If Yes, Please Describe):

Do You Regularly Engage In Any Religious Activities and/or Spiritual Practice(s):
--☐Yes --☐No
-Please Describe:

Do You Believe That Your Religious Belief/Spiritual Practice Impact On Your Treatment Needs?
--☐Yes --☐No
-Please Describe:

On a Scale from "1-10" With "10" Being the Absolutes Strongest, how Do You Rate The Strength of Your Religious Beliefs At This Time?

GENDER IDENTITY:-

What Is Your Gender? -☐Male -☐Female -☐Transgender -☐Other (Please Specify):

Are You Comfortable With Your Gender At This Stage Of Your Life
-☐Yes -☐No?

Have You Always Been Comfortable With Your Gender?
-☐Yes -☐No

CULTURE AND ETHNICITY:

What Is Your Cultural, Racial, or Ethnic Identification:

Have Your Cultural Identification, Practices And/or Beliefs Had An Impact On Your Lif
☐Yes --☐No
-(If Yes, Please Describe):

Does/ Will Your Culture And /Or Ethnic Identity Affect Your Treatment Needs?
-☐Yes --☐No (If Yes, Please Describe):

DRUGS AND ALCOHOL USE:

To The Best Of Your Knowledge, Is There a History Of Substance Abuse In Your Immediate And /Or Extended Family?
--☐Yes --- ☐No
-Please Describe:

USE OF NON-PHARMACEUTICAL SUBSTANCES:

Current	Past	Times per week / Comments
☐	☐ Tobacco	
☐	☐ Alcohol	
☐	☐ Drugs	
☐	☐ Coffee	
☐	☐ Soda	
☐	☐ Other_____	

Are you a recovering alcoholic? --☐Yes --- ☐No

Do You Have a History of drug or alcohol abuse? --☐Yes --- ☐No

Have You Engaged in Long term use of prescription/recreational drugs? --☐Yes --- ☐No
If yes, how often and in what form?

If yes, how often and in what form?

Do you use NutraSweet (aspartame)? --☐Yes --- ☐No

Do You Use Non-Pharmaceutical Substances --☐Yes --- ☐No

Do You Use Nutritional Supplements Such as Herbs / Minerals? --☐Yes --- ☐No

Do you Use Tobacco --☐Yes --- ☐No

List And Describe Any Family Use Of Alcohol And /Or Other Dugs:

Do (Have) You Experienced Any Of The Following Signs And Symptoms Associated W
Your Use Of Drugs?

☐Preoccupation With Using ☐Cravings ☐Urges To Use ☐Loss Of Control
☐Prescription Drug Abuse ☐Preferring To Use Rather Than Eat
☐Tolerance ☐Binge Use ☐Gastritis ☐Ulcers
☐Compulsive Behaviors ☐Concentration Problems ☐Jitteriness
☐ Delusions ☐Sneaking To Use ☐Hiding Use ☐Paranoia
☐Hearing Voices In Your head ☐Blackouts ☐Suspiciousness
☐Visual Hallucinations ☐Irritability ☐Use To Escape
☐Loss of Memory ☐Use To Relieve Stress ☐Use To Relieve Pain
☐Using To Cope ☐Using To Distract Self ☐Other: _____

How Many Times Have You Been Drunk In The Past Year?

How many Hangovers Have You Had In The Past Year?

What Factor(s) Are Limiting Your Use of Drugs or Alcohol Now?
-☐Cost ☐Availability ☐Guilt ☐Shame ☐Lack Of Desire ☐Drug Testing
Physical Problem

Have You Ever Harmed Yourself While Under The Influence of Alcohol Or Other Drug
Abuse? --
Yes --☐No
-Please Explain:

Do You Use Alcohol/drugs --☐Yes --- ☐No

How Often Do You Drink?

Do You Use Coffee/soda --☐Yes --- ☐No

How Much Do You Drink On An Average Occasion?

What Other non-food/ Substance/s Do You Use?

How Many Beers/Drinks Does It Take For You To Get A Buzz As Opposed To Getting Drunk?

Are you a recovering alcoholic? --☐Yes --- ☐No

Please Rate The Severity of Your Use Of Substances:
-☐Mild -☐Not Really A Problem -☐Moderate -☐A Severe Problem
-☐Out Of Control -☐Addicted

Do You Have a History of drug or alcohol abuse? --☐Yes --- ☐No

Screening CAGE:

Have You Engaged in long term use of prescription/recreational drugs? --☐Yes --- ☐No

Have you ever felt you should cut (C) down on your drinking? -☐Yes -☐No

Explain:

Alcohol and Drug Screening Analysis:

2. Have people annoyed (A) you by commenting on your drinking? -☐Yes -☐No
Explain:

Type of Question? Question?

Quantity-Frequency
Do you drink alcohol (beer, wine, or hard liquor)? --☐Yes --☐No
Please Explain>

Have people annoyed (A) you by commenting on your drinking? -☐Yes -☐No
Explain:

How often do you drink?

Have you ever felt bad or guilty (G) about your drinking?
-☐Yes - ☐No
Please Explain:

When you drink, about how much do you usually drink?

What is the most that you ever drink n a day?

How often do you drink your top amount?

What Is the Longest Period That You Have Gone Without Using Alcohol /Drugs?

Discuss (If applicable):

Have you ever had a drink first thing in the morning (Eye opener)?
-☐Yes -☐No
Please Explain:

Have You Ever Harmed Anyone Else While Under The Influence of Alcohol Or Other drug(s) of Abuse?
-☐Yes -☐No

Simple Screening Instrument for Substance Abuse Self-Administered: **Directions** ***questions that follow are about your use of alcohol and other drugs. Your answers will be kept private. Mark the response that best fits for you. Answer the questions in terms of you experiences in the past 6 months. During the last 6 months...***

1. Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroi other opioids, uppers, downers, hallucinogens, or inhalants)
--☐Yes --☐No

Simple Screening Instrument for Substance Abuse Self- Part II:
Directions: The questions that follow are about your use of alcohol and other drugs. Your answers will be kept private. Mark the response that best fits for you. Answer the questions terms of your experiences in the past 6 months. During the last 6 months...

9. Have you lost your temper or gotten into arguments or fights while drinking or using other drugs?
--☐Yes --☐No

2. Have you felt that you use too much alcohol or other drugs?
--☐Yes --☐No
**3. Have you tried to cut down or quit drinking or using alcohol or other drugs? **
--☐Yes --☐No
4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.)
--☐Yes --☐No
5. Have you had any health problems? For example, have you:
--☐Yes --☐No Had blackouts or other periods of memory loss?
--☐Yes --☐No Injured your head after drinking or using drugs?
--☐Yes --☐No Had convulsions, delirium tremens ("DTs")?
--☐Yes --☐No Had hepatitis or other liver problems?
--☐Yes --☐No Felt sick, shaky, or depressed when you stopped?
-☐Yes --☐No Felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs?
--☐Yes --☐No Been injured after drinking or using?
--☐Yes --☐No Used needles to shoot drugs?

6. Has drinking or other drug use caused problems between you and your family or friends? --☐Yes –☐No

10. Are you needing to drink or use drugs more and more to get the effect you want?
--☐Yes --☐No
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs?
--☐Yes --☐No
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, have unprotected sex with someone?
--☐Yes –☐No
13. Do you feel bad or guilty about your drinking or drug use?
--☐Yes –☐No

The next questions are about your lifetime experiences.

14. Have you ever had a drinking or other drug problem?
--Yes --No
--☐Yes –☐No
15. Have any of your family members ever had a drinking or drug problem?
--☐Yes –☐No

In The past thirty (30) Days How often Have You Used The Following Substances

Drug	Number of Days	
Any Alcohol		
Alcohol to intoxication (5+ Drinks In One Setting)		
Alcohol to Intoxication (4 or Fewer Drinks and Felt High)		
Tobacco *[In any form]*		
Illegal Drugs		
Cocaine/Crack		
Marijuana/Hashish (Pot, Joints, Blunts, Chronic, Weed, Mary Jane)		
Heroin **(Smack, H., Junk, Skag) or other Opiates**		
Heroin		
Morphine		
Dilaudid		
Demerol		
Percocet		
Darvon		
Codeine		
Tylenol 2, 3, 4		

When You Use, What (Which) Is (Are) Your Drug(s) Of Choice:--

☐Cocaine ☐Beer ☐Liquor ☐Marijuana ☐Hallucinogens ☐Barbiturates
☐Amphetamines ☐Caffeine ☐Nicotine ☐Tranquilizers ☐Narcotics
☐Painkillers ☐Prescription Drugs ☐Solvents ☐OTC Medication ☐Heroin
☐Methadone ☐Other _____

Of The Top Three Substances Indicated Above- Please Indicate The Frequency Of Your Use:

1. **☐AM Use ☐Afternoon Use ☐PM Use ☐PM Use Only ☐Daily Use**
☐Every Other Day ☐3-5 Times/Week ☐Less Than 1/Week
☐Weekends ☐Bi-Weekly ☐Monthly Amount _____

2. **☐AM Use ☐Afternoon Use ☐PM Use ☐PM Use Only ☐Daily Use**
☐Every Other Day ☐3-5 Times/Week ☐Less Than 1/Week
Weekends ☐Bi-Weekly ☐Monthly Amount _____

3. **☐AM Use ☐Afternoon Use ☐PM Use ☐PM Use Only ☐Daily Use**
☐Every Other Day ☐3-5 Times/Week ☐Less Than 1/Week
☐Weekends ☐Bi-Weekly ☐Monthly Amount _____

Non-prescription Methadone		
Hallucinogens/Psychedelics **PCP (Angel Dust, Ozone, Wack, Rocket Fuel, MDMA (Ecstasy, XTC Adam), LSD Acid, Boomers, Yellow Sunshine), Mushrooms, or Mescaline**		
Metamphetamine or Amphetamines **(Meth, uppers, speed, Ice, Chalk, Crystal, Glass, Fire, Crank)**		
Benzodiazipines: **Diapezepam (Valium); Alpeazolam (Xanax), Triazo (Halcion); and Estasolam (Prozom and Rohypnol-also known as roofies, roche, and cope)**		
Barbiturates: Mephobarbital (Mebacut); and pentobarbital sodium (Nembutal)		
Non-prescription GHB **(Known as Grievous Bodily Harm,** Liquid Ecst **and Georgia Home Boy)**		
Ketamine **(known as Special K, or Vitamin K)**		
Other tranquilizers; downers, sedative or hypnotics)		
Inhalants (Poppers, snappers, rush, whippets)		
Other Illegal Drugs (Specify) _____		

Have You Experienced Any Of The Following Consequences From Your Drug Use?

☐Emotional Problems ☐Family Discord ☐Loss of Pre-Drug Values
☐Health Problems ☐Marital Problems ☐Relationship Problems
☐Loss of Spouse ☐Loss of Loved One(s) ☐Threat of Separation
☐Threats of Divorce ☐Bankruptcy ☐Financial Problems
☐Loss of friends ☐Pending Court Case(s) ☐Legal Problems
☐DWI Arrest(s) ☐Positive Drug Screen ☐Traffic Violations
☐Traffic Accidents ☐Using At School ☐Using At Work
☐Thrown Out Of House ☐Impaired Coordination ☐Injuries ☐School Problems
☐Loss of Job ☐Disciplinary Action ☐Attendance Issues
☐Unusual Behavior While High
☐Other:

Were You Satisfied With How You Spent Your Free Time In The Past?
-☐Yes --☐No

Please Detail Your, Or Immediate Family Member's Previous Treatment For Chemical Dependency [Drug abuse]

(☐Inpatient Or, ☐Outpatient): ☐None ☐HX _____

Are You Using More Or Less Drugs Now?

How Would You Like To Spend Your Free Time Differently If You Could?

Have You Used Drugs Non-Stop Until You Just Had No More to Use/Take [Your supply was exhausted]? --☐Yes --☐No Explain:

HAVE YOU EVER BEEN TREATED FOR SUBSTANCE ABUSE IN YOUR WHOLE LIFE BEFORE NOW? --☐Yes --☐No ---☐N/A

Do You Over drink? --☐Yes --☐No
Please Explain:

Have You Attempted To Decrease [cut down on] The Amount Of Drugs/ Alcohol That You Use? --☐Yes --☐No
Please Explain:

How Many Times Have You Been Treated For Psychiatric/Neurological Issues in a Hospital?

LEISURE AND RECREATION

Do You Have Personal Interests, Hobbies, Leisure Activities, Or Organizations That You Att Or Belong To? ☐Yes --☐No

Have You EVER Been Treated For Mental Health Issues on an Outpatient Basis Before?
-☐Yes ---☐No ☐None ☐History

Are You Satisfied With How You Currently Spend Your Free Time?
-☐Yes --☐No
Please Discuss:

Do You Have A History Of Mental Health Treatment:
--☐Yes ---☐No-
Please Describe:

When:	Where:	Type of Program:	Outcome/Length Of Sobriety:

MEDICAL/MENTAL HEALTH HISTORY:

Hospital/ Provider:	Dates/ Duration:	Reason for Admission:	Length of Stay (How long w ou there?):	Outcome/ Benefit?

On the table below, please list any medications, including pharmaceuticals and antibiotics that you are currently or have previously taken.

Medication:	Dosage:	Reason/ Purpose [Prescribed for?] If Known)?	Frequency	Dates/ Duration	How Effective Has This Medication Been?
E.g. Wellbutrin	100 mg	Depression	2/day	December 2018-March 2019	Fatigue, etc.

Please List Your Health Concerns:

PRIMARY:

☐Mild ☐Moderate ☐Disabling ☐Constant ☐Intermittent
☐Symptoms ↑w/activity ☐Symptoms ↓w/activity
☐Getting worse ☐Getting better ☐No change

Treatment received

SECONDARY:

☐Mild ☐Moderate ☐Disabling ☐Constant ☐Intermittent
☐Symptoms ↑w/activity ☐Symptoms ↓w/activity
☐Getting worse ☐Getting better ☐No change

Have you ever received Energy Therapy before?
☐Yes ☐No
Frequency?

Have you ever received Manual Therapy before?
☐Yes ☐No
Frequency?

Please List Your Daily Activities:

Please, Describe Your Work Activities:

Treatment received

Home/Family

Social/Recreational

Check other activities affected:
☐sleep ☐washing ☐dressing ☐fitness
Circle [Check √] the above activities affected by your condition.
☐ **all of the above**

Major Illnesses

Have you ever received Psychotherapy before?
☐Yes ☐No
Frequency?

What kinds of practitioners (formal/informal) have you worked with around food/diet/nutrition [(example: Diet Health Coach, or Nutritional Therapist)]?

List all conditions currently being monitored by a Health Care Provider.

Work Hours and Schedule:

Do you now or have you ever worked the night shift
☐Yes ☐No
If so, please explain

If currently, what are your hours?

WOMEN:

Last Pap

First day of last menstrual period

Marital/Partner History (Years Married)

Number of Children

Ages of Children

Number of pregnancies

Complications of/ To Pregnancy[ies]:

Please List & include dates & treatments. [Add pages if necessary.]
Surgeries

Accidents (physical-psychological)

How do you reduce stress?

Pain?

Abortions/Miscarriages? ☐Yes ☐No

If so, please explain

Use of Contraceptive? ☐Yes ☐No
If so, please explain

What type?

Check all Current and Previous Conditions (please explain as relevant/ appropriate:

GENERAL

CURRENT	PAST	COMMENTS
☐	☐ Headaches	
☐	☐ Pain	
☐	☐ Sleep Disturbances	
☐	☐ Fatigue	
☐	☐ Infections in the ears	
☐	☐ Sinus	
☐	☐ Fever	
☐	☐ Other	

NERVOUS SYSTEM

CURRENT	PAST	COMMENTS
☐	☐ Head injures/ Concussions	
☐	☐ Dizziness/ Ringing in the Ears	
☐	☐ Loss of Memory/ Confusion	
☐	☐ Numbness/Tingling	
☐	☐ Sciatica/ Shooting pain	
☐	☐ Sinus	
☐	☐ Chronic pain	
☐	☐ Depression	
☐	☐ Other	

SKIN CONDITIONS

CURRENT	PAST	COMMENTS
☐	☐ Rashes	
☐	☐ Athlete's Foot	
☐	☐ Other	

RESPIRATORY/ CARDIOVASCULAR

CURRENT	PAST	COMMENTS
☐	☐ Heart disease	
☐	☐ Blood clot	
☐	☐ Stroke	
☐	☐ Lymphadema	
☐	☐ High/ Low blood pressure	
☐	☐ Irregular heartbeat	
☐	☐ Poor circulation	
☐	☐ Swollen ankles	
☐	☐ Varicose eins	
☐	☐ Pregnancy	
☐	☐ Chest pain/ Shortness of breath	
☐	☐ Asthma	
☐	☐ Palpable heartbeat n abdomen	
☐	☐ Other	

ALLERGIES

CURRENT:	PAST:	COMMENTS
☐	☐ Scents, oils, lotions	
☐	☐ Detergents	
☐	☐ Other	

MUSCLES & JOINTS

CURRENT	PAST	COMMENTS
☐	☐ Rheumatoid arthritis	
☐	☐ Osteoarthritis	
☐	☐ Scoliosis	
☐	☐ Broken bones	
☐	☐ Spinal problems	
☐	☐ Disc Problems	
☐	☐ Lupus	
☐	☐ TMJ/ Jaw pain	
☐	☐ Spasms/ Cramps	
☐	☐ Sprains/ Strains	
☐	☐ Tendonitis/ Bursitis	
☐	☐ Stiff or painful joints	
☐	☐ Weak or sore muscles	
☐	☐ Neck, shoulder, arm pain	
☐	☐ Low back, hip, leg pain	
☐	☐ Sprains/ Strains	
☐	☐ Tendonitis/ Bursitis	
☐	☐ Stiff or painful joints	

DIGESTIV/ ELIMINATION SYSTEM

CURRENT	PAST	COMMENTS
☐	☐ Bowel dysfunction	
☐	☐ Gas, bloating, Bladder/ Kidney dysfunction, abdominal pain	
☐	☐ Ulcers, colitis	
☐	☐ Belching/gas within 1 hour of eating	
☐	☐ Heartburn/ Acid reflux	
☐	☐ Bloating within 1 hour after eating	
☐	☐ Bad breath (halitosis)	
☐	☐ Sweat has strong odor	
☐	☐ Belching/gas within 1 hour of eating	
☐	☐ Heartburn/ Acid reflux	
☐	☐ Bloating within 1 hour after eating	
☐	☐ Bad breath (halitosis)	
☐	☐ Feel like skipping breakfast	
☐	☐ Feel better if you don't eat	
☐	☐ Feel better if you don't eat	
☐	☐ Sleepy after meals	
☐	☐ Stomach pains/cramps	
☐	☐ Diarrhea	
☐	☐ Undigested food in stool	
☐	☐ Pain between shoulder blades	
☐	☐ Stomach upset by greasy foods	
☐	☐ Nausea	
☐	☐ Light or clay colored stools, gallbladder attacks	
☐	☐ Diarrhea	
☐	☐ Gallbladder attacks	
☐	☐ Gallbladder removed	
☐	☐ Hemorrhoids or varicose veins	
☐	☐ Chronic fatigue / fibromyalgia	
☐	☐ Pulse speeds after eating	
☐	☐ Airborne allergies	

ENDOCRINE SYSTEM

CURRENT	PAST	COMMENTS
☐	☐ Thyroid dysfunction	
☐	☐ HIV/AIDS	
☐	☐ Diabetes	
☐	☐ Other	

REPRODUCTIVE SYSTEM

CURRENT	PAST	COMMENTS
☐	☐ Pregnancy	
☐	☐ Reproductive problems	
☐	☐ Painful, emotional menses	
☐	☐ Fibrotic cysts	
☐	☐ Cancer/Tumors	
☐	☐ Benign/ malignant	

☐	☐ Hives sinus congestion, "stuffy head"
☐	☐ Crave bread or noodles

DIGESTIVE/ ELIMINATION SYSTEM {CONTINUED}

CURENT	PAST	COMMENTS
☐	☐ Alternating constipation/diarrhea	
☐	☐ Crohn's disease	
☐	☐ Asthma	
☐	☐ Sinus infections	
☐	☐ Use over-the-counter pain medications	
☐	☐ Anus itches	
☐	☐ History of antibiotic use	
☐	☐ Fungus or yeast infections	
☐	☐ Irritable bowel/colitis	
☐	☐ Other	

EXERCISE ACTIVITIES:

Please fill in the approximate amount for each type of exercise that you do. Include the amount of time spent (hours/minutes) and the frequency.

Type	Hours	Minutes	Never	0-1 Times/Week	1-2 Times/ Week	3-5 Times/Week	Daily
E.g., Swim	*1*				*1*		
Bike							
Dance							
Garden							
Golf							
Hike							
Pilates							
Run							
Swim							
Tennis							
Ski							
Walk							
Weights							
Yoga							

Other:							
Other:							

Use of Nutritional Supplements / Herbs / Minerals

In the table below, please list any supplements, including vitamins, minerals, herbs, amino acids, and hormones that you are currently or have previously taken.

Supplements	Manufacturer	Dosage	Frequency	Dates/ Duration
E.g., Vitamin C	Bronson	500 mg	2X/Day	2012-4 Months

DETOXIFICATION

If you are currently or have previously done any detoxification methods, please indicate which ones by filling in the table below. If you have done a detoxification method that is not listed in the table, write the name of it in the row marked "other."

METHOD	HOW OFTEN	WHEN	DATES/ DURATION	DESIRED/ PERCEIVED BENEFITS
E.g., Skin brushing	*1-2 Times/Day*	*Before Bathing*	*2013-Present*	*Strengthen Immunity*
Skin Brushing				
Coffee Enema				
Liver Flush				
Juice Fast				
Colon Cleanser				
Epsom salt Bath (Magnesium sulphate)				
Salt and baking Soda Baths				
Vinegar Bath				
Sweats/ Sauna				
Castor Oil Packs				
Master Cleanse				
Other:				

BODY /PAIN / VISUAL ANALOG SCALE

PAIN/ DISCOMFORT

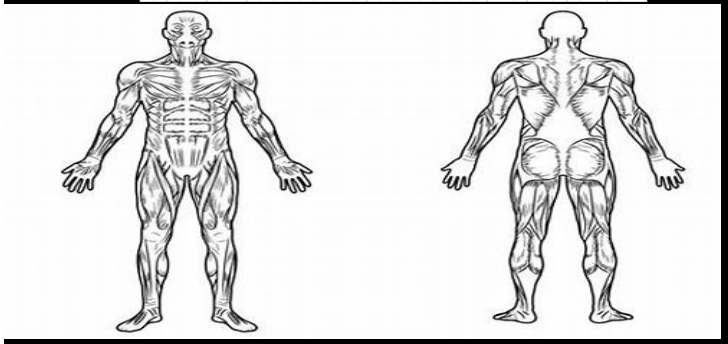
With a 0 to 10 scale, please rank how your pain feels from 0(no pain at all) to 10 (the worst pain imaginable)

Or

With a visual analog scale, please mark where your pain falls on a line that runs from "0" to "10" [from no pain (0) to the worst pain (10).

0 _____ 5 _____ 10

A = Ache B = Burning M = Memory site
N = Numbness P = Pins & needles
S = Sharp/Stabbing/ Scar or surgeries
O = Other: _____



Please, check the areas of pain or discomfort on the figures. Use the letters presented to identify the type of sensation. Please feel free to add any others you may wish to. Thank you!

Please describe the location and experience of pain:

Please, rate your stress level as of today [1-10]

CLIENT, PLEASE DO NOT WRITE BELOW THIS LINE!

☐Initial Assessment
☐Re-Assessment
☐Family
☐Other Provider(s): _____

Source/s Of Information For This Document:
☐Client ☐TX Records ☐Sig. Other

Referral Source: _____
Location of Assessment: _____
Interviewer: _____
Date(s): _____ Time: _____
Others Present? ☐Yes ☐No-- Who? _____

_____

Services Initially Requested:
☐Medication ☐Psychological TX ☐AODA TX. ☐Evaluation ☐Therapy ☐Crisis Assessment
Other?

OTHER CLINICAL COMMENTS:

STAFF	POSITON	DATE

QMHP DATE	DATE	DATE SEEN

LPHA/M.D.	DATE	DATE SEEN *[If Required]*