Demographic Information

Today's Date: __/__/____

Name: _____

Birth Date: __/__/____ Age: _____ Gender: _____

Address: _____ Home Phone: _____

_____ Cell Phone: _____

Email: _____

Which is your preferred method of contact? (please circle) Home Phone Cell Phone

What is a good time of day to reach you? _____

Reasons for Referral

Who referred you? _____

Briefly describe the reason you are here: _____
_____
_____
_____

How long has this reason been noticeable to you? _____

How old were you when the symptoms first occurred? _____

How often do you notice the problem? _____

What areas of your life are most affected and how (i.e. relationships, work, home)?
_____
_____
_____

Diagnoses (Yes No) If yes, please explain: _____
_____

What is the name of the doctor that made the diagnosis? _____

Are you currently taking any medications (including psychiatric/behavior medications)?

(Yes No) If yes, please write name(s) and dosage: _____
_____

What is your family/household composition (i.e. lives with spouse, parents, children)?
_____
_____

Medical History

Do you have any current medical or health concerns (Yes No) If yes, please list:
_____
_____

Do you have any chronic or recurrent medical or health concerns (i.e. diabetes, asthma)?
(Yes No) If yes, please list: _____
_____

Are you currently taking any medications for your medical condition? (Yes No) If yes, please list: _____
_____

Have any other family members shown similar difficulties or challenges? (Yes No) If yes, who?
_____
_____