ADVANCED BEHAVIORAL MEDICINE, PC

ADULT INTAKE INFORMATION

Name_____**Date:** _____

Address _____ **City:** _____ **State:** _____

Zip Code: _____ **Phone Number:** _____**Social Sec #** _____

Birthdate_____/_____/_____**ChildhoodReligion**_____**Religion Now**_____

Education_____**Occupation**_____**Employer** _____

Who referred you here? _____ **Primary Doctor** _____

Last Exam _____**Work hrs/wk:** _____ **TV/video hrs/wk** _____ **Exercise hrs/wk** _____

Major Interests: _____

What is the present difficulty? _____

_____

_____

_____

_____

_____

FAMILY STRUCTURE:

Name	Relationship	Age	If deceased, year	City of Residence
Your Current Household				
Other Children				
Other Immediate Relatives				
	Ex-Spouse			
	Mother			
	Father			
	Stepfather			
	Stepmother			

ADULT INTAKE INFORMATION

Medical Illnesses, Operations, Head Trauma, Seizures: _____

_____

Medications: _____

_____

_____

_____

_____

Drug Allergies: _____

_____

What alcohol or mood altering drugs do you use? How much? How often? _____

_____

Previous counseling, reason, outcome: _____

_____

_____

_____

_____

_____

What stressful life events have you experienced? _____

_____

_____

_____

_____

_____

What else do you want us to know about you? _____

_____

_____

_____

_____

_____