



**ADVANCED
BEHAVIORAL CARE**

Today's Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Social Security Number: _____

Gender: M F

Marital Status:	Married	Employment Status:	Full-Time
	Single		Part Time
	Separated		Retired
	Divorced		Disability
	Widowed		Student

Home Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: (____)____-____ Cell Phone: (____)____-____ Work Phone: (____)____-____

At which number(s) can we reach you? Home Cell Work

Email Address: _____

Would you like to receive reminder calls? Home Cell Work Text

May we leave you confidential messages? Home Cell Work None

Ethnicity:	Caucasian	How did you hear about us?:	Insurance
	African-American		Friend
	Asian		Physician
	Hispanic		Therapist
	Other		Other

Employment Information:

Employer Name: _____ Telephone: (____)____-____

Employer Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact:

Name: _____ Relationship: _____

Home Telephone: (____)____-____ Cell Phone: (____)____-____ Work Phone: (____)____-____

Address: _____

City: _____ State: _____ Zip: _____



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Primary Care Physician:

Name: _____

Address: _____

Telephone Number: _____ Fax Number: _____

Primary Preferred Pharmacy:

Name: _____

Address: _____

Telephone Number: _____ Fax Number: _____

Secondary Preferred Pharmacy:

Name: _____

Address: _____

Telephone Number: _____ Fax Number: _____

For Office Use ONLY:

Copay? _____

Pre-Auth Required? No Yes If yes, Auth. #: _____

Other Information:

Vitals:

Height _____ Weight _____

Blood Pressure _____

Pulse _____ Respiration _____



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Social History:

Religion, if any: _____

Interest/Hobbies: _____

Assuming that you are currently physically able to participate, are you currently able to enjoy those activities? Y N Infrequently Never

Current living situation: Live alone Live with others If others, who? _____

Family Social History:

Are your parents divorced? Y N If yes, how old were you when they separated? _____

Do you have any siblings? Y N If yes, how many? _____

Was your mother's pregnancy/delivery normal? Y N If no, please explain: _____

Education History:

Highest level of Education? 6 7 8 9 10 11 High School Graduate GED

College? Y N College Graduate? If yes, Degree: _____ Major: _____

Work History:

Are you currently employed? Y N

If yes, occupation?

If not currently working, why not?

Date last employed?

If disabled, please provide the nature of your disability:

Have you ever been in the military? Y N

If yes, which Branch? ARMY NAVY Air Force Marines

Approximate Dates? _____ Highest Rank: _____ Type of Discharge: _____

Legal History:

Have you ever been arrested? Y N

Have you ever been incarcerated? Y N

Pending charges? Y N

If yes, please describe: _____



Clinical Information:

Please describe your reason for seeking treatment today: _____

When (approx. date) did this problem start? _____

Was there an event/situation that made this problem worse? Y N

If yes, please describe that precipitating event: _____

Please indicate how your problems are affecting the following areas:

	No Effect			Significant Effect		
Marriage/Relationship	1	2	3	4	N/A	
Family	1	2	3	4	N/A	
Job/School	1	2	3	4	N/A	
Friends	1	2	3	4	N/A	
Hobbies	1	2	3	4	N/A	
Finances	1	2	3	4	N/A	
Physical Health	1	2	3	4	N/A	
Anxiety	1	2	3	4	N/A	
Mood	1	2	3	4	N/A	
Sexual Functioning	1	2	3	4	N/A	
Ability to Concentrate	1	2	3	4	N/A	
Temper/Irritability	1	2	3	4	N/A	
Spirituality	1	2	3	4	N/A	
Appetite	1	2	3	4	N/A	

If your appetite is affected, please describe how:

Have you gained or lost weight? Gained Lost

How Much? _____ Time period? _____

If your sleep is affected, please describe how:

Difficulty falling asleep? Y N

Are you waking during the night? Y N

If yes, how many times per night? _____

How long does it take to get back to sleep? _____

Overall, how many hours a night are you sleeping? _____



Psychiatric Treatment History:

Have you ever received psychological treatment of any kind? Y N

If so, describe the problems for which you sought therapy:

What diagnosis were you given? _____

What type of treatment did you receive? Inpatient Outpatient Both

Name of clinician	Phone Number/Address	Treatment dates
_____	_____	_____
_____	_____	_____
_____	_____	_____

Your experience with previous therapy: Positive Neutral Limited Negative

Have you ever been hospitalized for psychiatric problems? Y N

If yes, please list:

Date	Facility	Reason
_____	_____	_____
_____	_____	_____

Do you have any history of suicide attempts or history of assault? Y N

If yes, please explain:

Family Psychiatric History:

Has anyone in your family ever had a psychiatric disorder? Y N

If yes or unsure, please provide additional information (which family member, pertinent details regarding illness/symptoms, include any substance abuse)



Substance Abuse History:

Do you ever use recreational drugs? Y N If yes, how often? _____

Do you use alcohol? Y N If yes, how many drinks per day (average)? _____

Do you currently smoke cigarettes? Y N If yes, how many per day (average)? _____

If in the past, how many years? _____

Do you currently smoke a pipe? Y N If yes, how often (average)? _____

If in the past, how many years? _____

Do you currently chew tobacco? Y N If yes, how often (average)? _____

If in the past, how many years? _____

Please use this chart to provide more detailed information:

Substance:	Amount:	Frequency:	First Use:	Most Recent:

Have you ever felt like the use of any of the above created a problem for you? Y N

If yes, please describe: _____

Do you have any history of blackouts, seizures, or withdrawal symptoms? Y N

If yes, please describe: _____

Have you ever participated in an outpatient substance abuse treatment program (including 12 step groups)? Y N

If yes, please describe: _____

Medical History:

Allergies? Y N

If yes, please describe: _____

Do you have any existing medical problems or current physical symptoms of concern to you? If so, please describe: _____

Please indicate any major illnesses, accidents, and/or hospitalizations within the last 5 years:

_____ Date: _____

_____ Date: _____

Do you exercise? Regularly Occasionally Rarely Never



Current Medications:

Please list all current drugs/medications, including any over-the-counter medications you have taken in the last 30 days:

Medication	Dosage	Date

Medication History:

Medication	Dosage	Duration	Stop Date	Effectiveness (0 None – 10 Excellent)	Side Effects	Reason for stopping medication

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer, place an X in the box that best describes how you have felt and conducted yourself in the past 6 months.	Never	Rarely	Sometime	Often	Very
	1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?				
2. How often do you difficulty getting things in order when you have to do a task that requires organization?					
3. How often do problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

