

Describe any physical health problems.

---

---

---

What allergies do you have? \_\_\_\_\_

What medications do you take? Dosage? When did you begin taking these medications? \_\_\_\_\_

---

---

How many cigarettes a day do you smoke? \_\_\_\_\_ How long have you smoked? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ How many days per week do you typically drink? \_\_\_\_\_

When you drink, how many drinks do you usually have? \_\_\_\_\_

Which of the following have you experienced? \_\_\_\_\_ lost job because of drinking \_\_\_\_\_ missed work because of drinking  
\_\_\_\_\_ were in fights because of drinking \_\_\_\_\_ DUI \_\_\_\_\_ lost license \_\_\_\_\_ none

Which drugs do you, or did you abuse? \_\_\_\_\_ Does not apply \_\_\_\_\_ Narcotics \_\_\_\_\_ Recreational \_\_\_\_\_ Prescription

Has there been a change in your weight? \_\_\_\_\_ No \_\_\_\_\_ Weight gain \_\_\_\_\_ Weight loss \_\_\_\_\_ Yes, due to dieting

What problems do you have with your sleep? \_\_\_\_\_

Who in your family has been treated for psychological problems or problems with alcohol or drugs? \_\_\_\_\_

---

#### Current Situation

What is your current marital status? \_\_\_\_\_ How many times have you been married? \_\_\_\_\_

How long have you been married to your current spouse? \_\_\_\_\_ How many children have you had? \_\_\_\_\_

What is the age and gender of your children? \_\_\_\_\_

How many children currently live with you? \_\_\_\_\_

Have you had a significant loss or trauma in the past 2 years? \_\_\_\_\_ Please describe:

---

---

Briefly describe anything else you feel would be important for me to know about you.

---

---

---

---