

Patient Self-Report Sheet– ADULT¹

NAME _____ Date of Birth _____

ADDRESS _____

Home Phone: (____) _____ **May we leave a msg?** **YES NO**

Cell/Other phone: (____) _____ **May we leave a msg?** **YES NO**

Emergency Contact: NAME _____ **Phone** _____

Please circle: Never married partnered married

separated divorced widowed

If married, how many marriages have you had? _____

List the people currently living in your house

Name	Age	Relationship to You	Occupation

Who Referred You? _____

Briefly describe your goals for therapy:

¹ Bold print indicates topics required by NCQA or other insurers.

Mental Health Background

List any psychotropic medications (medications for your nerves) that you are taking.

Medication	Dose/Frequency	When Started	For What Symptom(s)?

List any previous mental health or substance abuse treatment (include any inpatient or hospital treatment for a mental health or substance abuse disorder) that you have had.

Date of Treatment (approximate)	Name of Treatment Provider or Agency	What Was Your Problem at the Time?	Were Your Treatment Goals Met?

Was anything in your previous treatment particularly helpful? Not helpful? _____

At this time do you ever have thoughts of harming yourself? YES _____ NO _____

Have you ever attempted suicide? YES _____ NO _____

At this time do you ever have thoughts of harming others? YES _____ NO _____

Social History

Education (please circle)

Did Not Finish High School

High School

Some College

College

Graduate or Professional School

Occupation _____

Current Employer (or School) _____

How long have you worked there? _____

Describe your religious or spiritual orientation? _____

If you have a religion, how often do you attend religious services? (Circle one)

At least weekly

monthly

several times a year

once a year or less

Which of the following statements best describe you (check all that apply)

_____ I have a lot of friends with whom I can confide in or count on

_____ I have many close family members with whom I can confide in or count on

_____ I have a few close friends with whom I can confide in or count on

_____ I have a few close family members with whom I can confide in or count on

_____ I have a lot of friends, but I can't confide in them or count on them

_____ I have few friends and none whom I can confide in or count on

Would you say that you are lonely?

_____ frequently

_____ occasionally

_____ sometimes

_____ rarely

Does your family have a history of mental illness or substance abuse? If so, please explain the nature of the problem, treatment they received and indicate if any particular medication was helpful.

Legal History

Legal Event		If Yes, please give a brief description
Have you ever been arrested?	YES NO	_____ _____ _____
Have you ever been arrested for a DUI (Drinking under the influence?)	YES NO	_____ _____ _____
Have you ever been in prison?	YES NO	_____ _____ _____
Are you currently involved in any litigation?	YES NO	_____ _____ _____

Medical Information

Name of primary care physician or provider _____

Do I have your permission to send basic information (presenting problem, summary of treatment, relevant health information, etc.) to your primary care provider?

YES _____ NO _____

If yes, you will need to sign a specific “authorization” or “release of information form” in order for me to contact your primary care provider.

How would you describe your physical health?

___ excellent ___ good ___ average ___ poor ___ very poor

List any non prescription (over-the-counter) medications that you take?

Drug	Dose/Frequency	When Started	For What Symptom(s)?

Do you have any allergies or sensitivities to drugs, foods, or other substances?

YES _____ NO _____

If yes, please indicate the substances that you are allergic to or have sensitivities to:

Do you smoke or use other tobacco products? YES _____ NO _____

If yes, please indicate what you smoke (or chew) and how much you smoke or chew in an average day.

Do you drink alcohol? YES _____ NO _____

If yes, please indicate what you drink and how much you drink in an average day.

Do you use recreational drugs such as marijuana, cocaine, or other drugs?

YES _____ NO _____

If yes, please indicate what you use how much you use in an **average week**.

Is there any other information that would be useful to know about you?
