Name/Practice Name: _____
Address: _____
Address: _____
City, State, ZIP:
_____
_
Phone:
_____
_____
Fax:

_____

PATIENT INTAKE: SOCIAL/FAMILY HISTORY

(To be completed by patient)

Patient Name: _____

(Circle one) Married Single Long-term relationship Divorced/Separated

Years married/in long-term relationship: _____Times married: _____Times divorced: _____

Children? **( )** N **( )** Y Current ages (Please list) _____

Residing with you? **( )** N **( )** Y If no, where? _____

Where are you currently living? _____

Do you have family nearby? **( )** N **( )** Y (Please describe) _____

Education (check most recent degree):

( ) Graduate School **( )** College **( )** Professional or Vocational School

( ) High School Grade _____

Are you currently employed? **( )** N **( )** Y Where (if no, where were you last employed)? _____

What type of work do/did you do? _____ How long have/did you work(ed) there? _____

Have you ever been arrested or convicted? **( )** N **( )** Y (Check all that apply)

( ) DWI **( )** Drug-related **( )** Domestic violence **( )** Other _____

Have you ever been abused? **( )** N **( )** Y

( ) Physically **( )** Sexually (including rape or attempted rape) **( )** Verbally **( )** Emotionally

Have you ever attended:

AA: **( )** Current **( )** Past **NA:** **( )** Current **( )** Past **CA:** **( )** Current **( )** Past

ACOA: **( )** Current **( )** Past **OA:** **( )** Current **( )** Past

If you are not currently attending meetings, what factors led you to stop? _____

Have you ever been in counseling or therapy? **( )** N **( )** Y (Please describe) _____