Willow Creek Clinic
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Intake and Personal History Form

Name: _____ Social Security Number: _____
Gender: ___F ___M Date of Birth: _____ Age: _____
Form completed by (if someone other than client): _____
Address: _____
City: _____ State: _____ Zip Code: _____ May we contact you at your listed address: ___Y ___N
Phone: (Home) _____ (Cell) _____
May we contact you at your home and/or cell phone number: ___Y ___N
E-mail Address: _____ May we contact you via e-mail: ___Y ___N
Person Responsible for Payment: _____ Social Security Number: _____
Relationship to Patient: _____
Signature of Person Responsible for Payment: _____ Date: _____
(This must be signed for services to begin)

Pharmacy Information:
Name: _____ Address: _____ Phone: _____

Emergency Information (In case of emergency, contact):
Name: _____ Relationship: _____ Phone: _____

Referral Source:
How did you hear about our office or from whom did you hear about our office?
_____
Telephone Number: _____ Fax Number: _____ Do you want us to contact them? ___Y ___N

Primary reason(s) for seeking services (Please describe in detail):
_____
_____
_____
_____

Development

Are there special, unusual, abusive or other traumatic circumstances that affected your development? ___Y ___N
If yes, please describe: _____
_____
Please describe significant events in your life including marriages, separations, divorces, births, and, deaths: _____
_____

Social Relationships

Marital Status (Married, divorced, separated, single, widow): _____
Assessment of current relationship (if applicable): ____Good ____Fair ____Poor
Children (Please list names and ages): _____
Siblings (Name, ages, relationship to patient): _____
Family Structure: (Who lives in your current household? Please give relationship to each person.): _____
_____
Previous Marriages (Please list dates and reason for separation): _____
_____
Sexual Orientation: _____ Comments: _____
Please describe your social support network (check all that apply):
___Family ___Neighbors ___Friends ___Students ___Co-Workers ___Community Group
___Support/Self-Help Group ___Religious/Spiritual Center (which one): _____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? _____
If you are experiencing any difficulties due to cultural or ethnic issues, please describe: _____
_____
Religion (if any): _____
How important are spiritual matters to you? ___Not at all ___Little ___Somewhat ___Very Much
Would you like spiritual/religious beliefs to be incorporated into your counseling? ___Y ___N

Legal

Are you involved in any active cases (traffic, civil, criminal)? ___Y ___N
If yes, please describe and indicate the court and hearing/trial dates and charges: _____
_____
Are you presently on probation/parole? ___Y ___N If yes, please describe: _____

Past History:
Traffic Violations: ___Y ___N DWI, DUI, etc: ___Y ___N
Criminal Involvement: ___Y ___N Civil Involvement: ___Y ___N

Education

Fill in all that apply: Years of Education: _____ Currently enrolled in school? ___Y ___N
___High School Grad/GED
___College: _____ # of Years: _____ Graduated: ___Y ___N Major: _____
Other Training: _____
Special Circumstances (e.g., learning disabilities, gifted): _____

Employment

Occupation: _____ Employer: _____
Stress Level of Current Position: ___Low ___Medium ___High
Currently: ___FT ___PT ___Temp ___Laid-Off ___Disabled ___Retired ___Social Security ___Student
___Other (Describe): _____
Summarize jobs you've had including favorite and least favorite as well as how long you worked there: _____
_____
_____
Any work-related problems: _____
Have you been/are you current in the military? ___Y ___N (If no, skip the remainder of this section.)
Branch: _____ Date of Discharge: _____ Type of Discharge: _____ Rank: _____
Were you in combat: ___Y ____N Please describe if yes: _____
_____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.):

Activity	How Often Now?	How Often in the Past?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical/Physical Health

Primary Care Physician: _____ Phone: _____
Address: _____ Fax: _____
Past General State of Health: ___Excellent ___Good ___Fair ___Poor
Current Weight: _____ Usual Weight: _____ Maximum Weight: _____ Minimum Weight: _____ Height: _____
Sexual History: (Answer only as much as you feel comfortable)
Age at time of first sexual experience: _____ Number of sexual partners: _____
Any history of sexually transmitted disease: _____ History of abortion: _____
History of sexual abuse, molestation or rape: _____
Current sexual problems: _____

Check all that apply below:

___Hay Fever	___Skin Trouble	___Phlebitis	___Polyps	___Migraines
___Mumps	___Cataracts	___Hypertension	___Kidney Infections	___Epilepsy
___Measles	___Tonsillitis	___Stroke	___Kidney Stones	___Paralysis
___Rheumatic Fever	___Sinusitis	___Ulcers	___Bladder Trouble	___Polio
___Allergies	___Goiter	___Jaundice	___Diabetes	___Mental Illness
___Anemia	___Asthma	___Gallstones	___Syphilis	___Alcoholism
___Cancer	___Bronchitis	___Liver Disease	___Gonorrhea	___Depression
___Tumor	___Pleurisy	___Pelvic Infection	___Hernias	___Nervous Breakdown
___Blood Diseases	___Pneumonia	___Hepatitis	___Sexual Problems	___Abnormal Bone Growth
___Leukemia	___HIV	___Parasites	___Hemorrhoids	___Other_____
___Fibromyalgia	___Tuberculosis	___Dysentery	___Arthritis	_____
___Breast Trouble	___Heart Disease	___Colitis	___Gout	_____
	___Varicose Veins			

Please describe any major illnesses, injuries, head trauma, or operations you have had including dates: _____
_____

Any history of seizures or seizure-like activity: _____
Sleep Behavior: Sleepwalking, nightmares, recurrent dreams, current problems (getting up, going to bed): _____
_____

Radiology:
Prior abnormal lab tests, X-rays, EEG, etc: _____
_____
_____

Recent Symptoms (Please check the symptoms that you have experienced recently):

General
- ____ Weakness
- ____ Fatigue
- ____ Fever
- ____ Chills
- ____ Night Sweats
- ____ Fainting
- ____ Tire Easily
- ____ Disturbed Sleep
- ____ Weight Changes

Head
- ____ Headaches
- ____ Pain
- ____ Injuries
- ____ Bumps
- ____ Contusions
- ____ Migraines
- ____ Coma
- ____ Concussion
- ____ TBI

Eyes
- ____ Blurred Vision
- ____ Glaucoma
- ____ Redness
- ____ Itching
- ____ Burning
- ____ Swelling
- ____ Pain
- ____ Dryness
- ____ Tearing
- ____ Loss of visual field

Ears
- ____ Hard of Hearing
- ____ Deafness
- ____ Ringing
- ____ Discharge
- ____ Earache
- ____ Itching
- ____ Loss of Balance
- ____ Dizziness
- ____ Room Spins

Nose
- ____ Decreased Smell
- ____ Bleeding
- ____ Pain
- ____ Discharge
- ____ Obstruction
- ____ Post Nasal Drip
- ____ Deviated Septum
- ____ Runny Nose
- ____ Sinus Congestion
- ____ Dryness

Mouth
- ____ Bleeding Gums
- ____ Sores
- ____ Dental Problems
- ____ Pain
- ____ Bad Breath
- ____ Loss of Taste
- ____ Dry Mouth
- ____ Ulcers
- ____ Blisters
- ____ Broken Teeth

Throat
- ____ Soreness
- ____ Bad Tonsils
- ____ Hoarseness
- ____ Pain
- ____ Trouble Swallowing
- ____ Recurrent Infections

Neck
- ____ Enlargements
- ____ Stiff Neck
- ____ Soreness
- ____ Lymph
- ____ Masses
- ____ Guarded
- ____ Radiating
- ____ Pain

Lungs
- ____ Cough
- ____ Phlegm
- ____ Blood
- ____ Short of Breath
- ____ Wheezing
- ____ Pain
- ____ Congestion
- ____ Inhalant

Heart
- ____ Murmur
- ____ Palpitation
- ____ Rapid Heartbeat
- ____ Swollen Extremities
- ____ Cold Extremities
- ____ Blue Extremities
- ____ Chest Pain/Pressure
- ____ Varicose Veins
- ____ Blood Clots

Skin
- ____ Color Changes
- ____ Nail Changes
- ____ Hair Changes
- ____ Moles
- ____ Rashes
- ____ Itching
- ____ Sores
- ____ Dryness

Blood
- ____ Anemia
- ____ Easy Bruising
- ____ Easy Bleeding
- ____ Swollen Nodes
- ____ Painful Nodes
- ____ Sugar in Blood
- ____ Red Spots

Endocrine
- ____ Weight Loss
- ____ Weight Gain
- ____ Hoarseness
- ____ Heat Intolerance
- ____ Cold Intolerance
- ____ Breast Changes
- ____ Hair Changes
- ____ Extreme Thirst

Gynecological
- ____ Spotting Between Periods
- ____ Menstrual Cramps
- ____ Spotting After Menopause
- ____ Discharge
- ____ Itching
- ____ Painful Intercourse
- ____ Irregular Periods
- ____ Hot Flashes

Contraception Type _____
Age at First Period _____
Age at Menopause _____
Duration of Cycle _____
Duration of Flow _____
# of Pregnancies _____
# of Births _____
# of Miscarriages _____
# of Abortions _____

Menstrual Flow
- ____ Heavy
- ____ Moderate
- ____ Light

Date of Last Period: _____
Date of Last Pap: _____
- ____ Normal
- ____ Abnormal

Breasts
- ____ Discharge
- ____ Lumps
- ____ Pain
- ____ Bleeding
- ____ Nipple Changes
- ____ Skin Changes
- ____ Tenderness
- ____ Cysts

Date of Last Mammogram: _____

Gastrointestinal
- ____ Abdominal Pain
- ____ Nausea
- ____ Belching
- ____ Indigestion
- ____ Irregular Bowel Habits
- ____ Food Intolerance
- ____ Bloody Stools
- ____ Black Stools
- ____ Poor Appetite
- ____ Bloating
- ____ Vomiting
- ____ Heartburn
- ____ Constipation
- ____ Hemorrhoids
- ____ Gas
- ____ Hernias
- ____ Melina
- ____ Diarrhea

Genitourinary
- ____ Urgency
- ____ Straining
- ____ Incontinence
- ____ Back Pain
- ____ Frequency
- ____ Burning
- ____ Stones
- ____ Bed Wetting
- ____ Small Stream
- ____ Dribbling
- ____ Discharge
- ____ Sores
- ____ Impotence
- ____ Cloudy Urine

Urine Color:_____

Musculoskeletal
- ____ Muscle Pain
- ____ Muscle Cramps
- ____ Muscle Weakness
- ____ Muscle Twitching
- ____ Joint Deformities
- ____ Strain/Sprain
- ____ Misalignment
- ____ Curvature of Spine
- ____Back Pain
- ____Injuries
- ____Joint Pain
- ____Hot Joints
- ____Tenderness
- ____Joint Stiffness
- ____Joint Swelling

Psychological
- ____ Hyperventilation
- ____ Hallucinations
- ____ Loss of Memory
- ____ Troubled Sleep
- ____ Suicidal Thoughts
- ____ Extreme Worry
- ____ Drug Addiction
- ____ Drug Dependency
- ____ Sexual Problems
- _____Timid
- _____Anxious
- _____Indecisive
- _____Alcoholism
- _____Insecurity
- _____Irritable
- _____Depression

PHYSICAL CHANGES
- ____ Chronic Sleep Disturbances
- ____ Increased Infections
- ____ Feeling Tired All the Time
- ____ Hearing Impairment
- ____ Lack of Fine Motor Coordination
- ____ Muscle Spasticity
- ____ Difficulty Controlling Blood Pressure
- ____ Body Temperature Changes
- ____ Weight Gain
- ____ Changes in Hair Texture
- ____ Speech Impairment
- ____ Other Sensory Impairment
- ____ Dizziness or Imbalance
- ____ Seizure Disorders
- ____ Gait Impairments
- ____ Changes in Skin Texture
- ____ Thyroid Disease
- ____ Paralysis
- ____ Abnormal Bone Growth
- ____ Double Vision
- ____ Field Cuts
- ____ Near-Sightedness
- ____ Sector Losses
- ____ Rapid Eye Movement

COGNITIVE CHANGES
- ____ Short and Long-Term Memory Loss
- ____ Impaired Reading and Writing Skills
- ____ Trouble Making Decisions
- ____ Impaired Concentration
- ____ Impairments of Perception
- ____ Slowed Thinking
- ____ Limited Attention Span
- ____ Communication Difficulties
- ____ Impaired Planning or Sequencing Abilities
- ____ Impaired or Changed Judgment Skills

PSYCHO-SOCIAL CHANGES
- ____ Listlessness
- ____ Fatigue
- ____ Denial
- ____ Agitation
- ____ Easily Irritated for Little or No Reason
- ____ Frequent Mood Changes or Swings
- ____ Excessive Laughing or Crying
- ____ Difficulty Relating to Others
- ____ Lowered Self-Esteem
- ____ Inability to Cope
- ____ Inability to Self-Monitor
- ____ Self-Centeredness
- ____ Sexual Dysfunction
- ____ Difficulty with Emotional Control
- ____ Lack of Motivation
- ____ Restlessness

Chemical Use History

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours Yes	Used in last 48 hours No	Used in last 30 days Yes	Used in last 30 days No
Alcohol								
Barbiturates								
Valium/Xanax								
Cocaine/Crack								
Heroin/Opiates								
Marijuana								
PCP/LSD/Mescaline								
Inhalants								
Caffeine								
Nicotine								
Over the Counter								
Prescription Pain Meds								
Other Drugs								

Substance Abuse Questions:

Describe when and where you typically use substances: _____

Describe any changes in your use patterns: _____

Describe how your use has affected your family or friends (include their perceptions of your use):_____

_____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use?_____

Have you ever needed detoxification/rehabilitation for alcohol or drugs? ___Y ___N

If yes, describe with dates and locations: _____

Over the Counter Medications

Medication:	Type:	Dosage:	Frequency:
Laxatives:			
Antacids:			
Diet Pills:			
Pain Pills:			
Aspirin:			
Diuretics:			
Sleeping Pills:			
Vitamins:			
Minerals:			
Herbs:			
Others:			

Prescriptions

Local Pharmacy Name: _____ Telephone: _____ Fax: _____

Mail Order Pharmacy: _____ Telephone: _____ Fax: _____

Medication:	Dosage:	Frequency:

Medication Allergies:

___I do not have any medication allergies.

Medication:	Reaction:

Family Psychiatric/Substance Abuse History

Please list and describe any family members who have/had any psychiatric issues or problems with substance abuse: (i.e. bipolar disorder, depression, anxiety, ADD, substance abuse, autism, learning disability): _____
_____
_____
_____

Prior Psychiatric Treatment History

Current Therapist/Clinician: _____ Phone: _____
Address: _____ Fax: _____
Prior Psychiatric Hospitalizations: ___Y ___N If yes, please describe (hospital, dates, reason): _____
_____
Have you ever had thoughts, made statements, or attempted to hurt yourself? ___Y ___N If yes, please describe: __
_____
Have you ever had thoughts, made statements, or attempted to hurt someone else? ___Y ___N If yes, please describe:
_____
Current Psychiatric Medications and Dosage: _____
_____
Prior Trials of Psychiatric Medications: _____
_____

Please check behaviors and symptoms that occur to you more often than you would like them to take place.

___Aggression	___Elevated Mood	___Phobias/Fears
___Alcohol Dependence	___Fatigue	___Recurring Thoughts
___Anger	___Gambling	___Sexual Addiction
___Antisocial Behavior	___Hallucinations	___Sexual Difficulties
___Anxiety	___Heart Palpitations	___Sick Often
___Avoiding People	___High Blood Pressure	___Sleeping Problems
___Chest Pain	___Hopelessness	___Speech Problems
___Cyber Addiction	___Impulsivity	___Suicidal Thoughts
___Depression	___Irritability	___Thoughts Disorganized
___Distractibility	___Loneliness	___Trembling
___Disorientation	___Judgment Errors	___Withdrawing
___Dizziness	___Memory Impairment	___Worrying
___Drug Dependence	___Mood Shifts	___Other(specify): _____
	___Eating Disorder	___Panic Attacks
		_____

Please check if there have been any recent changes in the following:

___Sleep Patterns	___Eating Patterns	___Behavior	___Energy Levels
___Physical Activity Level	___General Disposition	___Weight	___Nervousness/Tension

Describe changes in areas in which you checked above or any other changes noticed: _____
_____

Final Questions

Any additional information that would assist us in understanding your concerns or problems: _____
_____
_____
_____
What are your hopes/goals for treatment: _____
_____
_____
_____

Signature: _____ Date: _____