FAMILY HISTORY			ALLERGIC TO	PREVIOUS MEDICAL/SURGICAL HISTORY
Yes	No		Medication – please list:	List dates/place/type of treatment:
		Alcoholism		
		Kidney Disease		
		Heart Disease		
		Lung Disease		
		Drug Abuse		
		H/L Blood Pressure		
		Cancer	Food – Please list:	Are you ill now? ☐ No ☐ Yes
		Liver Disease		What medications are you taking?
		Suicide		
		Diabetes		
		Convulsions		
Other:				

PREVIOUS PSYCHIATRIC TREATMENT	PREVIOUS SUBSTANCE ABUSE TREATMENT
List Dates/Place/Type of treatment:	List dates/place/type of treatment:
Have you ever experienced an overdose? ☐ Yes ☐ No If YES, was the overdose intentional? ☐ Yes ☐ No If YES, were you hospitalized? ☐ Yes ☐ No	

PAIN SCREENING

Are you currently experiencing any physical pain? ☐ Yes ☐ No *(If no, please skip to Nutrition Section)*	If you experience any physical pain, please describe the cause:
If yes, please indicate the location:	

On a scale of 1 to 10, with one being the least and 10 the most, please rate degree of pain you experience.

Are you currently under a physician's care for the pain? ☐ Yes ☐ No

NUTRITION SCREENING

Have you experienced a recent weight loss or weight gain? ☐ Yes ☐ No
If YES, please indicate the amount lost or gained and over what period of time ______________________________
Do you follow a special diet for medical, personal or other reasons? ☐ Yes ☐ No
If YES, please indicate the type of diet that you follow ______________________________
Do you take any dietary supplements? ☐ Yes ☐ No
If YES, please describe the supplements and the reason for taking them ______________________________
Do you have any difficulty chewing or swallowing? ☐ Yes ☐ No
If YES, please describe the difficulty ______________________________
Do you use any herbal remedies or follow alternative medicine? ☐ Yes ☐ No
If YES, please describe ______________________________

LEISURE ASSESSMENT

Do you participate in regular leisure activities? ☐ Yes ☐ No
If YES, please specify:______________________________
____
When you participate in leisure activities, do you participate alone or with others? ☐ Alone ☐ w/others
If "with others", please indicate who those persons are:______________________________
____
Do you feel that you have adequate leisure time? ☐ Yes ☐ No
If NO, please explain why:______________________________
____

______________________________ ______________________________

Date Therapist's Signature

Physical Exam: ☐ Recommended ☐ Not Recommended Referred to: ______________________________