AUSBORN BEHAVIORAL CARE, PC

Initial Patient Information for Adult

Name:______________________________ Birthdate:____________________

Address:______________________________ Today's Date: ____/____/________

______________________________ Phone: (H) ____________________

Employer:______________________________ Parent (W) ____________________

Address______________________________ Patient SSN: ____________________

FAMILY INFORMATION

Marital status: _____ Married _____ Yrs. _____ Never married _____ Separated

_____Divorced _____ Yrs. _____ Widowed _____ Yrs.

Children (names and ages): ____

____

Household: ___ Home ___ Apartment ___ Live with parents/other family ___ Live with roommate(s)/other

___ Group home/residential treatment center ___ Incarcerated

Will family or others participate in your counseling? ___ If so, who will participate?

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

WORK/EDUCATION INFORMATION

Profession/type(s) of work: ____

Years in current field of work: ___ Years in other fields: ___ Years formal education: ___

Work/education goals: ____

MEDICAL AND OTHER INFORMATION

Please list any medical problems currently being treated for:______________________________

Please list any medications you take:____

In case of a medical or other emergency, please tell us who you would like us to call:

Name:______________________________ Phone:______________________________

Address: ______________________________ Relationship: ______________________________

SUBSTANCE ABUSE INFORMATION

Do you feel you have a drug or alcohol problem? ______ If yes, why? ______________________________

What is your drug of choice (the drug, including alcohol, you use most often)?______________________________

How often have drugs been used in the past? _____ How much do you usually use?____________________

Date of first use? ________________ When was the last time you used this drug?____________________

What is the longest you have voluntarily gone without this drug?________ Why?____________________

What other drugs used in the past 6-months?____

Please briefly describe the drug or alcohol related event that caused you to come to treatment?______________

____

COUNSELING INFORMATION

Reason for coming to counseling/desired services: ____

Previous counseling?_________________________ If so, please give us the following information:

Purpose/Issues:	Name of Counselor:	When & for How Long:	Results:
______________	____________________	____________________	____________________

What are your goals for the outcome of counseling and how you hope your life will be different:______________

____