



Name: _____

Date of Birth: _____ Social Security Number _____

Address: _____

Phone Numbers:
Home _____ Work _____

Mobile _____

Email Address _____

Referred by: _____

In Case of Emergency who would you like me to contact?

If you have OSU insurance I will need all information also bring your card to your initial appointment.

Policy holder _____ Policy # _____

Group # _____

Insurance Billing Info/Address _____

Family Physician/Internist: _____

Address: _____

Phone: _____



Employment or Student Status:

Employer: _____

Job Title: _____

College or University: _____ Year: _____

Spouse or Partner:

Name: _____

Employer: _____

Address: _____

Job Title: _____

Work Phone: _____

Past or Current Mental Health Services

Therapy: _____

Medications: _____

Name of Therapist: _____

Address: _____

Phone: _____

Hospitalizations:

Name of Hospital: _____

Address: _____

Doctor's Name: _____



What is the main problem (s) for you at this time?

What have you tried to solve this problem?

What has helped?

Are you currently receiving treatment for this problem? Yes No

If yes, describe: _____

Circle any family or life stresses that might have brought on or added to your problems:

Financial pressure legal problems move(s) job change(s) divorce

Separation Marriage or new relationship birth of child

Serious conflicts in marriage or relationship child leaving home

Medical problems death(s) traumatic experiences

Other: _____



Please check any of the following that are problems for you:		
	X	Comments
Feelings of sadness, depression		
Difficulty handling anger		
Feeling very nervous		
Panic		
Difficulty with sleep		
Difficulty with eating, appetite		
Being very irritable, edgy		
Crying too easily		
No energy		
Unable to enjoy anything		
Difficulty concentrating or memory		
Thinking about death		
Thinking about suicide		
Thinking about hurting someone		
Annoying thoughts that won't go away		
Excessive worries		
Annoying habits or behaviors		
Hearing voices		
Feeling confused		
Feeling out of control		
Concern about weight		
Concern about appearance		
Difficulty with friends		
Difficulty with spouse or partner		
Difficulty with children		
Difficulty with parents		
Difficulty with brothers or sisters		
Difficulty with co-workers or boss		
Unhappy with job/school		
Other		



Medical History

Check and describe any of the following conditions you now have or have had in the past:		
Problem	X	Description of Problem
Allergies to Medicines		
Serious Drug Reaction		
Diabetes		
Thyroid Condition		
Heart Condition		
High Blood Pressure		
Asthma, Bronchitis		
Emphysema		
Stomach Problems, Ulcer		
Colitis		
Kidney or Bladder Problems		
Headaches		
Menstrual Problems		Date of last menstrual period:
Prostate Problems		
Sexual Problems		
Pregnancy		Number of pregnancies: Number of births:
Vision Problems / Color Blind		
Glaucoma		
Hearing Problems		
Multiple Sclerosis		
Seizures		
Chronic Pain		
HIV Positive		
AIDS		



Tuberculosis		
Hepatitis		
Sexually Transmitted Disease		
Arthritis		
Physical Handicap		
Very Underweight		
Very Overweight		
Anemia		
Cancer		
Hospitalizations		
Surgery		
Fractures (broken bones)		
Serious Injuries or Accidents		
Other		
At the present time, list your use of:		
Prescription medicines now being taken:		
Special Diet:		
Weekly Exercise (time, type)		
Daily Tobacco Use:		
Daily Amount of Caffeine Drinks: (coffee, colas, tea)		
Weekly Use of Alcohol (beer, wine, liquor, Other):		
Weekly Use of Drugs (marijuana, LSD, Other):		



FAMILY MENTAL HEALTH HISTORY

Check the item if there is any family member with the problem (parents, sisters, brothers, cousins, aunts, uncles, grandparents, etc.)

Illness or Problem	X	Relation to you
Alcoholism		
Drug Abuse		
Other Addictive disorders		
Depression		
Deliberately Harmed Self		
Suicide Attempt		
Suicide		
Attention Problems or "ADD"		
Hyperactivity		
Learning Problems or Dyslexia		
Tics or Tourette's Disorder		
Special Classes in School		
Mental Retardation		
Obsessive Compulsive Disorder		
Severe Anxiety, Fears, or Phobias		
Panic Attacks		
Manic Depressive or Bipolar disease		
Schizophrenia		
Victim of Physical Abuse		
Victim of Sexual Abuse or Rape		
Post Traumatic Stress Disorder		
Violent or Abusive Behavior		
Violent Sexual Behavior, Rape		
Trouble with the Law		
Jail Sentence		
Other:		



FAMILY MEDICAL HISTORY

Check the item if there is any family member with the problem (parents, sisters, brothers, cousins, aunts, uncles, grandparents, etc.)

Illness	X	Relation to You
AIDS		
Cancer		
Diabetes		
Heart Disease		
High Blood Pressure		
Kidney Disease		
Multiple Sclerosis		
Seizures		
Sickle Cell Anemia		
Stroke		
Tuberculosis		
Sudden Death		
Sever Injury		
Other:		