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)
_____