DATE OF INTAKE:_____

Clinical Record

NAME	**(First)**	**(Middle)**	**(Last)**	**SSN:**	
				Date of Birth:	**Age:**
				Cell Number:	
SPOUSE NAME	**(First)**	**(Middle)**	**(Last)**	**SSN:**	
				Date of Birth:	**Age:**
				Cell Number:	
Residence Address	**(Street/House#)**		**(City/Town)**	**(State)**	**(Zip)**
Phone:		**Insurance Carrier:**		**Insurance ID:**	

Family History:_____

Born and raised where?_____

Parents together or divorced? Living? Emotionally close to any parent figures?_____

_____

Siblings? Emotionally close to any siblings?_____

Do you have any history of being exposed to any kind of abuse or violence?_____

_____

What do you do for fun?_____

Exercise?_____

Religious/Spiritual?_____

Marital History:_____

Married? How long?_____

Kids?_____

Any separations? If so , how long?_____

Prior Marriages?_____

Who all lives with you?_____

_____

_____

Brief History, Including Hospitalizations, Outpatient Treatment:

Medical:_____

_____

_____

_____

_____

Counseling History:_____

_____

_____

Family History of Mental Health:_____

_____

_____

Medications:_____

_____

_____

_____

Work/School History, Military Service:_____

_____

_____

Spouse Work/School History, Military Service:_____

_____

_____

Alcohol/Other Drug Usage History:_____

_____

Family History of Addiction:_____

_____

Legal History:_____

_____