



**PLEASE COMPLETE OTHER SIDE TOO**

PLEASE DESCRIBE ANY PRIOR THERAPY YOU HAVE RECEIVED. INCLUDE DATES, NAME(S) OF THERAPIST AND NATURE OF PROBLEM.

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PLEASE DESCRIBE THE PRESENT PROBLEM:

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WHAT DO YOU HOPE TO ACCOMPLISH THROUGH THERAPY?

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PLEASE DESCRIBE ANY HEALTH PROBLEMS.

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DO YOU SMOKE: ( )YES ( )NO      SPOUSE/PARTNER: ( )YES ( )NO

DO YOU DRINK ALCOHOL?( )YES ( )NO      SPOUSE/PARTNER: ( )YES ( )NO

WHAT KIND/HOW MUCH/HOW OFTEN? \_\_\_\_\_

DO YOU USE ANY OTHER SUBSTANCES? (i.e. MARIJUANA, COCAINE, ETC.) ( )YES ( )NO

SPOUSE/PARTNER: ( )YES ( )NO

WHAT KIND/HOW MUCH/HOW OFTEN? \_\_\_\_\_

ARE YOU TAKING ANY MEDICATION?( )YES ( )NO      SPOUSE/PARTNER: ( )YES ( )NO

DESCRIBE \_\_\_\_\_

DO YOU HAVE ANY TROUBLE SLEEPING?( )YES ( )NO      SPOUSE/PARTNER: ( )YES ( )NO

DESCRIBE \_\_\_\_\_

RECENTLY GAINED ( ) OR LOST ( ) WEIGHT

HOW MUCH/OVER HOW LONG? \_\_\_\_\_ / \_\_\_\_\_

ARE YOU CURRENTLY BEING TREATED FOR ANY PHYSICAL OR PSYCHOLOGICAL ILLNESS? ( )YES ( )NO

DESCRIBE \_\_\_\_\_

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NAME OF PHYSICIAN \_\_\_\_\_ DATE OF LAST PHYSICAL EXAM \_\_\_\_\_