

**MENTAL HEALTH CLIENT INTAKE FORM**

Disclaimer: Thank you for your interest in being a client of [CLINIC'S NAME]. This form is used to collect information about new clients and for internal purposes only. The information you provide is confidential and will be treated accordingly.

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| **PERSONAL INFO** |

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

-Do you give permission for ongoing regular updates to be provided to your primary care physician? [ ]  Yes [ ]  No

**Current Therapist/Counselor**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Therapist Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **REASONS FOR VISIT** |

**What are the problems for which you are seeking help?**

**Current Symptoms**:(check all that apply)

[ ]  Racing thoughts [ ]  Depressed mood [ ]  Impulsivity

[ ]  Sleep pattern
 disturbance

[ ]  Avoidance [ ]  Excessive worry

[ ]  Forgetfulness

[ ]  Unable to enjoy
 activities

[ ]  Fatigue

[ ]  Suspiciousness [ ]  Loss of interest [ ]  Change in appetite

[ ]  Anxiety attacks [ ]  Excessive guilt [ ]  Increased risky behavior

[ ]  Increased irritability [ ]  Increased libido [ ]  Hallucinations

[ ]  Excessive energy [ ]  Decreased libido [ ]  Decreased need for
 sleep

[ ]  Crying spell [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **SUICIDE RISK ASSESSMENT** |

**Have you ever had feelings or thoughts that you didn’t want to live?** [ ]  Yes [ ]  No

If yes, please answer the following. If no, please skip to the next section.

-Do you **currently** feel that you don’t want to live? [ ]  Yes [ ]  No

-How often do you have these thoughts? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

-When was the last time you had thoughts of dying? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

-Has anything happened recently to make you feel this way? [ ]  Yes [ ]  No

-On a scale of 1 to 10, how strongly do you feel these thoughts? \_\_\_\_\_\_

-Would anything make it better? [ ]  Yes [ ]  No

-Have you ever thought about how you would kill yourself? [ ]  Yes [ ]  No

-Is the method you would use readily available? [ ]  Yes [ ]  No

-Have you planned a time for this? [ ]  Yes [ ]  No

-Is there anything that would stop you from killing yourself? [ ]  Yes [ ]  No

-Do you feel hopeless and/or worthless? [ ]  Yes [ ]  No

-Have you tried to kill or harm yourself before? [ ]  Yes [ ]  No

-Do you have access to firearms? If yes, please explain below. [ ]  Yes [ ]  No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **PAST MEDICAL HISTORY** |

**Do you have any allergies?** If yes, specify them:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Weight:** \_\_\_\_\_\_\_\_\_ **Current Height:** \_\_\_\_\_\_\_\_\_

**List any prescription medication that you are currently taking and how often you are taking them:**

Medication Total Daily Dosage Estimated Start Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current over-the-counter medication or supplements**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current medical problems**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past medical problems, nonpsychiatric hospitalization, or surgeries**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever had an EKG?** [ ]  Yes [ ]  No

If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ How was the EKG? [ ]  Normal [ ]  Abnormal [ ]  Unknown

*For women only*
**Date of last menstrual period**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birth control method**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently pregnant or do you think you might be pregnant?** [ ]  Yes [ ]  No

**Are you planning to get pregnant in the near future?** [ ]  Yes [ ]  No

**How many times have you been pregnant?** \_\_\_\_\_\_\_ **How many live births?** \_\_\_\_\_\_\_\_

**Any concerns about your physical health that you would like to discuss?** [ ]  Yes [ ]  No

If yes, please specify:

**Date of last physical exam**: \_\_\_\_\_\_\_\_\_ **Location**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **PERSONAL AND FAMILY MEDICAL HISTORY** |

**Check any that apply to you or a member of your family (specify who if selected)**:

Thyroid disease

Anemia

Liver disease

Chronic fatigue

Kidney disease

Diabetes

Asthma/respiratory problems

Stomach or intestinal problems

Cancer

Fibromyalgia

Heart disease

Epilepsy or seizures

Chronic pain

High cholesterol

High blood pressure

Head trauma

Liver problems

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  You [ ]  Family member (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

[ ]  You [ ]  Family member (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

[ ]  You [ ]  Family member (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

[ ]  You [ ]  Family member (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

[ ]  You [ ]  Family member (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

[ ]  You [ ]  Family member (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

[ ]  You [ ]  Family member (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

[ ]  You [ ]  Family member (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

[ ]  You [ ]  Family member (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

[ ]  You [ ]  Family member (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

[ ]  You [ ]  Family member (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

[ ]  You [ ]  Family member (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

[ ]  You [ ]  Family member (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

[ ]  You [ ]  Family member (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

[ ]  You [ ]  Family member (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

[ ]  You [ ]  Family member (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**Any other additional personal or family medical history?**

**When your mother was pregnant with you, were there any complications during the pregnancy or birth?** [ ]  Yes [ ]  No

If yes, please specify:

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| **PSYCHIATRIC HISTORY** |

**Outpatient Treatment?** [ ]  Yes (if yes, specify the details below) [ ]  No

Reason Date Treated By Whom

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Psychiatric Hospitalization?** [ ]  Yes (if yes, specify the details below) [ ]  No

Reason Date Hospitalized Where

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List any psychiatric medication you have taken, the dates, dosage, and any side effects:**

Medication Date. Dosage Side Effects

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **FAMILY PSYCHIATRIC HISTORY** |

**Has anyone in your family been treated for**:

[ ]  Bipolar disorder [ ]  Depression [ ]  Anxiety [ ]  Anger [ ]  Suicide [ ]  Schizophrenia

[ ]  Post-traumatic stress [ ]  Alcohol abuse [ ]  Violence [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If any of the options were selected, specify the family member and the corresponding problem:

**Has any family member been treated with psychiatric medication? If yes, who was treated, what medications did they take, and how effective was the treatment?**

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| **SUBSTANCE USE** |

**Have you ever been treated for alcohol or drug use or abuse?** [ ]  Yes [ ]  No

-If yes, for which substances? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

-If yes, where were you treated and when? Date: \_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How many days per week do you drink alcohol?** \_\_\_\_

**What is the least and the most # of drinks you will drink in a day?** Least: \_\_\_\_ Most: \_\_\_\_

**What is the most alcohol you have consumed in a day in the last 90 days?** \_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever felt you should cut down on your drinking or drug use?** [ ]  Yes [ ]  No

**Have people annoyed you by criticizing your drinking or drug use?** [ ]  Yes [ ]  No

**Have you ever felt bad or guilty about your drinking or drug use?** [ ]  Yes [ ]  No

**Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?** [ ]  Yes [ ]  No

**Do you think you may have a problem with alcohol or drug use?** [ ]  Yes [ ]  No

**Have you used any street drugs in the past 3 months?** [ ]  Yes [ ]  No

-If yes, which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever abused prescription medication?** [ ]  Yes [ ]  No

-If yes, which ones and for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever tried any of the following?**

Substance If so, how long and when did you last use?

[ ]  Methamphetamine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Cocaine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Stimulants (pills) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Heroin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  LSD or Hallucinogens \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Marijuana \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Painkillers (not as prescribed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Methadone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Tranquilizer/sleeping pills \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Alcohol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Ecstasy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **PERSONAL HABITS** |

**How many caffeinated beverages do you drink a day?** Coffee \_\_\_\_ Sodas \_\_\_\_ Tea \_\_\_\_

**Have you ever smoked cigarettes?** [ ]  Yes [ ]  No

-Currently? [ ]  Yes [ ]  No

If yes, how many packs per day on average? \_\_\_\_ How many years have you smoked? \_\_\_\_\_\_

-In the past? [ ]  Yes [ ]  No

If yes, how many years did you smoke? \_\_\_\_\_\_\_\_ When did you quit? \_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you exercise regularly?** [ ]  Yes [ ]  No

-How many days a week? \_\_\_\_\_\_\_ How much time each day? \_\_\_\_\_\_\_

-What kind of exercise do you do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **PERSONAL DETAILS** |

**Were you adopted**? [ ]  Yes [ ]  No **Where did you grow up?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List your siblings and their ages:**

Name Age

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_

**What is/was your parent’s occupation?** Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Did your parents divorce?** [ ]  Yes [ ]  No

-If yes, what age were you? \_\_\_\_\_ Who did you live with? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Describe your father and your relationship with him**:

**Describe your mother and your relationship with him**:

**How old were you when you left home?** \_\_\_\_\_\_\_

**Has anyone in your immediate family died?** If yes, specify who and when:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have a history of being abused emotionally, sexually, physically, or by neglect?** If yes, describe when, where, and by whom:

**Highest education level attained?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employment status**: [ ]  Working [ ]  Student [ ]  Unemployed [ ]  Disabled [ ]  Retired

-How long have you been in your present position? \_\_\_\_\_\_\_

-If working or retired, what is/was your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

-What location do/did you work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever served in the military?** [ ]  Yes [ ]  No

-If yes, what branch? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When did you serve? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

-Were you honorably discharged? [ ]  Yes [ ]  No [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital status**: [ ]  Married [ ]  Partnered [ ]  Divorced [ ]  Single [ ]  Widowed

-How long have you been in your present status? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

-If not married, are you currently in a relationship? ☐ Yes ☐ No If yes, how long? \_\_\_\_\_\_\_\_\_\_

-If you have a partner or spouse, what is their occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

-Describe your relationship with your partner or spouse:

**Have you had any prior marriages?** [ ]  Yes [ ]  No

-If so, how many? \_\_\_\_ How long were/was the marriage(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you sexually active?** [ ]  Yes [ ]  No **What is your sexual orientation?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any children?** [ ]  Yes [ ]  No

If yes, specify their age and gender:

Age Gender

\_\_\_\_ \_\_\_\_\_\_\_\_\_

\_\_\_\_ \_\_\_\_\_\_\_\_\_

\_\_\_\_ \_\_\_\_\_\_\_\_\_

\_\_\_\_ \_\_\_\_\_\_\_\_\_

Describe your relationship with your children:

**List everyone who currently lives with you**:

**Have you ever been arrested?** [ ]  Yes [ ]  No **Any pending legal problems?** [ ]  Yes [ ]  No

**Do you belong to a particular religion or spiritual group?** [ ]  Yes [ ]  No

If yes, what is the level of your involvement? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you?** [ ]  More helpful [ ]  Stressful

**Is there anything else that you would like us to know?**

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| **ACKNOWLEDGMENT** |

Signature: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_](https://esign.com/) Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian Signature (if required) [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_](https://esign.com/) Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_