Name:_____ Occupation: _____

Date: _____ Date of Birth: _____ Marital Status: _____

Highest Level of Education: _____ Children: _____

1. What is the main problem today? _____

_____

2. Do you have other concerns today? YES NO

3. Have you ever seen a psychiatrist, psychologist, social worker or counselor before? YES NO

4. Are you taking any medication, prescribed or over the counter? YES NO

_____

5. Do you drink alcohol? How much? _____ YES NO

How often? _____

6. Do you drink caffeine? Cups of coffee/day? _____ YES NO

Cola drinks/day? _____

Cups of tea/day? _____

7. Do you use tobacco? What form? _____ YES NO

How much? _____

8. Do you take recreational drugs? YES NO

9. Are you having problems on the job or at school? YES NO

10. Are you having problems sleeping? (too much, too little) YES NO

11. Has your appetite increased or decreased? YES NO

12. Do you ever make yourself throw up? YES NO

13. Have you been feeling sad? YES NO

14. Have you had thoughts of hurting yourself? YES NO

15. Do you sometimes feel too happy or excited? YES NO

16. Do you sometimes feel you can't control your thoughts or actions? YES NO

17. Are you worried about losing your temper? YES NO

18. Are you afraid you might hurt someone? YES NO

19. Are there times for which you have no memory? YES NO

20. Have you ever had any unusual experiences? YES NO

21. Are you having trouble with your memory? YES NO

22. Do you have trouble concentrating? YES NO

23. Is reading difficult for you? YES NO

24. Do you wish you had either more or less interest in sex? YES NO

25. Do you ever feel there is more than one person inside of you? YES NO

26. Have you ever been physically or verbally abused? YES NO

27. Have you ever been sexually molested? YES NO

28. Are you worried about the behavior of someone close to you? YES NO

29. Are you having problems with your husband/wife, or boyfriend/girlfriend? YES NO

30. Are you having problems with a child? YES NO

31. Are you having problems with a parent or in-law? YES NO

32. Do you have any major physical worries? YES NO

___heart ___intestines ___allergies

___lungs ___kidneys ___cancer

___stomach ___reproductive organs ___joints

___vision ___hearing ___handicaps

___other: _____

33. Have you ever been in the hospital? YES NO

When? _____

What was the problem? _____

34. Are you on a special diet? YES NO

35. Have you consulted a chiropractor, naturopath, or nutritionist? YES NO

36. Do you exercise regularly? YES NO

What form(s): _____

How often? _____

37. Please indicate if you have a religious or spiritual affiliation: YES NO

_____

Are you currently active in this affiliation? YES NO

38. Are you a member of a service or social organization? YES NO

_____

39. Is there anything else I should know about you?

_____

_____