PATIENT SELF- REPORT

Name:_____ Date:_____

Age:_____ Marital Status:_____

Household Members:_____

Occupation: _____

Employer:_____

Educational History:
Highest grade/degree completed_____

Employment Status:
Employed: Full-time ___ Part-time ____ Self-employed _____ Unemployed _____

Student _____ Homemaker _____ Other _____

Medical History:
Currently under doctor's care? Yes No

Please list any current medical problems: _____
_____

Medications currently used: NONE

Medication/Dose/ Prescribed? Date Prescribed	Doctor Prescribing	Why

Past Hospitalizations (Medical, Psychiatric, Chemical Dependency): NONE

Date(s) Hospital	Reasons

Previous Counseling, EAP or Chemical Dependency Services: NONE

Facility/Counselor Name	Dates	Reason	Helpful?
			Yes No
			Yes No
			Yes No

If yes, what was particularly *helpful* or *not helpful* about these services? What needs to be different about your time here, if anything?

Have you ever taken leave from work for mental health or chemical dependency problems?
Yes No If yes, please explain:

Legal History:

Have you ever been arrested?	Yes	No
Have you ever been convicted of a crime?	Yes	No
Are you presently on parole or probation?	Yes	No

If yes, please explain?

Financial History:
Are you having any financial problems? If so can you describe in general terms.

Have you ever felt the need to bet more and more money? If yes, please explain

Have you ever had to lie to people important to you about how much you gambled?

Current/Past Substance Use: (include tobacco/ alcohol use)

Substance	Time Period Used	Frequency of Use	Amount	Age at First Use

Have you ever tried or felt the need to cut down on your drinking or use of other drugs?
If yes, please explain:

Have you ever felt annoyed, irritated or defensive when someone has talked to you about, or criticized your drinking or use of other drugs?
If yes, please explain:

Have you ever felt guilty or remorseful about your drinking or your use of other drugs or about things you did; or the ways you treated others when you were drinking or using other drugs?
If yes, please explain:

Have you ever had a morning eye-opener? Do you ever use early in the morning or shortly after you wake up?
If yes, please explain:

Have you in the past had any thoughts of harming yourself or someone else? Yes No
If yes, please explain (include dates):

Have you acted on these thoughts? Yes No

If yes, please explain (include dates):

Do you currently have any thoughts of harming yourself or someone else? Yes No
If yes, please explain:

Do you have a plan for acting on these thoughts? Yes No
If yes, please explain:

Family History of mental illness or emotional problems? Yes No

History of Substance abuse problems? Yes No

History of Attention Deficit Hyperactivity Disorder? Yes No

History of Learning Disabilities? Yes No

If yes, please explain:

Thank You