Joan B. Jablow, APMHNP
45 Byram Lake Road
Mt. Kisco, New York 10549
jablownp@optimum.net
(914) 241-1246

Personal—Adult (18+)

Client's name: _____ Date: _____
Gender: _____ F _____ M Date of birth: _____ Age: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone (home): _____ (work) _____ ext: _____

Please describe the issues you would like to discuss:

_____
_____
_____
_____

Significant Relationships (please fill in any you consider significant, including those not listed, such as siblings or grandparents):

	Living	Age	Living with you
Mother	Yes / No	_____	Yes / No
Father	Yes / No	_____	Yes / No
Spouse/Partner/Significant Other	Yes / No	_____	Yes / No
Child	Yes / No	_____	Yes / No
_____	Yes / No	_____	Yes / No
_____	Yes / No	_____	Yes / No
_____	Yes / No	_____	Yes / No
_____	Yes / No	_____	Yes / No
_____	Yes / No	_____	Yes / No
_____	Yes / No	_____	Yes / No

Marital Status (more than one answer may apply)

_____ Single _____ Divorce in process _____ Unmarried, living together
_____ Legally married _____ Separated _____ Divorced
Total number of marriages: _____

Development

Are there special, unusual, or traumatic circumstances that affected your development? Yes / No
If yes, please describe: _____

_____

Has there been a history of child abuse? Yes / No
If yes, which type (s)? _____ Sexual _____ Physical _____ Verbal

Social Relationships

How do you generally get along with other people: (check all that apply)

_____ Affectionate _____ Aggressive _____ Avoidant
_____ Fight/argue often _____ Follower _____ Friendly
_____ Leader _____ Outgoing _____ Shy/withdrawn
_____ Submissive _____ Other (specify) _____

Sexual orientation: _____

Cultural/Ethnic

How important are spiritual matters to you?
_____ Not at all _____Some _____ A lot

Are you affiliated with a spiritual or religious group? Yes / No
If yes, please describe: _____

Were you raised within a spiritual or religious group? Yes / No
If yes, please describe: _____

Would you like your spiritual/religious beliefs incorporated into the counseling? Yes / No
If yes, please describe: _____

Legal

Are you involved in any active cases (traffic, civil, criminal)? Yes / No

Are you currently on probation or parole? Yes / No

If yes, please describe: _____

Education

What is your highest level of education?

_____ High school / GED
_____ Some college
_____ Undergraduate degree
_____ Graduate degree
_____ Other: please describe _____

Employment

Currently employed? Yes / No
Employer: _____ Job title: _____

Military

Military experience? Yes / No Combat experience? Yes / No
Where: _____
Branch: _____ Discharge date: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

_____
_____
_____
_____

Medical/Physical Health

Please check which of the following you have had or currently have:

_____ AIDS
_____ Alcoholism
_____ Abdominal pain
_____ Abortion
_____ Allergies
_____ Anemia
_____ Appendicitis
_____ Arthritis
_____ Asthma
_____ Bronchitis
_____ Bedwetting
_____ Cancer
_____ Chest pain
_____ Chronic pain
_____ Colds/coughs
_____ Constipations
_____ Dental problems
_____ Diabetes
_____ Diarrhea
_____ Dizziness
_____ Drug abuse
_____ Epilepsy
_____ Ear infections
_____ Eating problems
_____ Fainting
_____ Fatigue
_____ Frequent urination
_____ Headaches
_____ Hearing problems
_____ Hepatitis
_____ High blood pressure
_____ Kidney problems
_____ Measles
_____ Mononucleosis
_____ Mumps
_____ Menstrual pain
_____ Mononucleosis
_____ Nausea
_____ Nosebleeds
_____ Pneumonia
_____ Rheumatic fever
_____ Sexually transmitted diseases
_____ Sleeping disorders
_____ Sore throat
_____ Scarlet fever
_____ Sinusitis
_____ Stroke
_____ Sexual problems
_____ Tonsillitis
_____ Tuberculosis
_____ Thyroid problems
_____ Vision problems
_____ Vomiting
_____ Whooping cough
_____ Other (please describe

List any current health concerns not mentioned above: _____
List any recent health or physical changes: _____
_____

Current prescribed medications _____ Dose _____

Current over-the-counter medications _____ Dose _____

Are you allergic to any medications or drugs? Yes / No

If yes, please describe: _____
_____

	Date	Reason	Results
Last physical exam	_____	_____	_____
Last doctor's visit	_____	_____	_____
Last dental exam	_____	_____	_____

Most recent surgery _____ _____ _____

Other surgery _____ _____ _____

Upcoming surgery _____ _____ _____

Family history of medical problems: _____

Please check if there have been any recent changes in the following:

__ Sleep patterns ___ Eating patterns ___ Behavior ___ Energy level

__ Physical activity level ___ General disposition ___ Weight

__Nervousness/tension

Chemical Use History

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol								
Barbiturates								
Valium/Librium								
Cocaine/Crack								
Heroin/Opiates								
Marijuana								
PCP/LSD/Mescaline								
Inhalants								
Caffeine								
Nicotine								
Over the counter								
Prescription drugs								
Other drugs								

Substance of preference

1. _____ 3. _____
2. _____ 4. _____

Substance Abuse Questions

Describe when and where you typically use substances: _____

Describe any changes in your use patterns: _____

How does it affect your life? _____

_____

Who or what has helped you in stopping or limiting your use? _____

_____

Does/has someone in your family have/had a problem with drugs or alcohol? Yes / No

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? Yes / No

If yes, please describe: _____

Have you had adverse reactions or overdose to drugs or alcohol? (Describe):_____

_____

Mental Health History

Please check which of the following behaviors and symptoms you have:

___ Aggression
___ Alcohol dependence
___ Anger
___ Antisocial behavior
___ Anxiety
___ Avoiding people
___ Chest pain
___ Cyber addiction
___ Depression
___ Disorientation
___ Distractibility
___ Dizziness
___ Drug dependence
___ Eating disorder
___ Elevated mood
___ Fatigue
___ Gambling
___ Hallucinations
___ Heart palpitations
___ High blood pressure
___ Hopelessness
___ Impulsivity
___ Irritability
___ Judgment errors
___ Loneliness
___ Memory impairment
___ Mood shifts
___ Panic attacks
___ Phobias/fears
___ Recurring thoughts
___ Sexual addiction
___ Sexual difficulties
___ Sick often
___ Sleeping problems
___ Speech problems
___ Suicidal thoughts
___ Thoughts disorganized
___ Trembling
___ Withdrawing
___ Worrying
___ Other (specify): _____
_____

Briefly discuss how the above symptoms impair your ability to function effectively:_____

_____

_____

_____

_____

Is there any other information you would like me to know before we begin our discussion?

_____

_____

_____

_____