NEW ENGLAND
CENTER FOR ANXIETY

Today's date: _____

Name: _____ Date of birth: _____ Age: ____

Social Security #: _____

Home street address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ E-mail: _____

Cell: _____

Employer: _____ Work phone: _____

Please describe the main difficulty that has brought you to see me:

1. Have you ever before received psychological, psychiatric, drug or alcohol treatment, or counseling services?
❑ No ❑ Yes When? From whom? For what? With what results?_____

2. Have you ever taken medications for psychiatric or emotional problems? ❑ No ❑ Yes
When? From whom? Which medications? For what? With what results?____

List all medications, drugs, or other substances (not listed above) you take or have taken in the last year–prescribed, over-the--counter vitamins, herbs, and others.

Medication/drug	Dose (how much?)	Taken for	Prescribed and supervised by

From whom or where do you get your medical care?
Clinic/doctor's name: _____ Town: _____

Your education and training

Dates From	Dates To	Schools	Special classes?	Adjustment to school	Did you graduate?

Employment and military experiences

Dates From	Dates To	Name of employers	Job title or duties	Reason for leaving

Married/in relationship?

Children?

Who lives in the home?

Main social supports?

Current religious denomination/affiliation ❑ Protestant ❑ Catholic ❑ Jewish ❑ Islamic ❑ Buddhist ❑ Hindu
Other (specify): _____

Involvement: ❑ None ❑ Some/irregular ❑ Active

How important are spiritual concerns in your life? _____

Ethnicity/national origin: _____ Race: _____

Chemical use
How many cups of regular coffee do you drink each day? _____ How many cups of tea? ____.

How many sodas with caffeine? ____

How many "energy drinks"? ____ How often do you use No Doz or similar caffeine pills? _____ .

Do you use tobacco ❑ No ❑ Yes. Yes. If yes, how many cigarettes/cigars/other do you use each day? _____

How much alcohol (beer, wine, hard liquor) do you drink each week?

Have you ever used inhalants ("huffing"), such as glue, gasoline, or paint thinner? ❑ No ❑ Yes If yes, which and when?

Which drugs (not medications prescribed for you) have you used in the last 10 years?

Health History
1. Starting with your childhood and proceeding up to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had.

Age	Illness/diagnosis	Treatment received	Treated by	Result

2. Describe any allergies you have.

To what?	Reaction you have	Allergy medications you take

Health habits
1. What kinds of physical exercise do you get?

2. How much coffee, soda, tea, or other sources of caffeine do you consume each day? Which?

3. Do you try to restrict your eating in any way?

4. Do you have any problems getting enough sleep? ❑ No ❑ Yes. If yes, what problems?

Abuse history:
❑ No ❑ Yes

Your age	Kind of abuse	By whom?	Effects on you?	Whom did you tell?	Consequences of telling?

Legal history

1. Are you presently suing anyone or thinking of suing anyone? ❑ No ❑ Yes. If yes, please explain: _____
_____
_____

2. Is your reason for coming to see me related to an accident or injury? ❑ No ❑ Yes If yes,please explain: _____
_____
_____

3. Are you required by a court, the police, or a probation/parole officer to have this appointment? ❑ No ❑ Yes