CORE TREATMENT SERVICES INCORPORATED

Current Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Number of Years Married: _____ Total Number of Marriages: _____

Do you have any children? ☐ Yes ☐ No Ages: _____

Living Arrangements: ☐ Own House ☐ Bio Family ☐ Foster Family ☐ Transitional

Ethnicity: _____ Language Preferred for Services: _____

Emergency Contact: _____ Relationship: _____

Phone: _____ Address: _____

Military

Have you ever served in the military? ☐ Yes ☐No

Dates of Service: _____ Branch of Service: _____

Current Health Problems: ☐ No ☐ Yes If yes, describe:

Check the following that apply:

_____ High blood pressure ___ Heart Disease ____ Epileptic Seizures

_____ Blackouts/fainting ___ Memory Loss ____ Difficulty Concentrating

_____ Liver disease ___ Infectious Hepatitis ____ Hepatitis B/C

_____ Childhood diseases ___ Herpes or other Sexually Transmitted Diseases (STD)

_____ Human Immunodeficiency Virus (HIV) ____ Other:

Physical Symptoms (Circle any that were a problem for you in the last month):

Headaches	Dizziness	Vision Changes	Muscle/Joint Pain
Sexual Problems	Diarrhea	Chest Pains	Muscle Tension
Fatigue	Fainting/Blackouts	Rapid Heartbeat	Tics/Twitches
Chills/Hot Flashes	Sweating	Muscle Spasms	Nausea
Shortness of Breath	Trembling/Shaking	Numbness	Stomach Ache
History of Head	Mouth	Skin Problems	
Injury/Trauma	Heart Pounding	Choking Sensations	

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List any medications you are currently taking:

Medication Name	Dose	Reason

Adverse response to medications: ☐ No ☐ Yes If yes, describe: _____

If Female, are you on any form of birth control? ☐ Yes ☐ No

Are you, or is there a chance you might be pregnant? ☐ Yes ☐ No

Height: _____ **Weight:** _____

Sleep Disturbance: ☐ No ☐ Yes If yes, describe: _____

Appetite: ☐ Too Little ☐ Too Much weight gain: _____ lbs. weight loss:_____ lbs.

Allergies – Food or Other: _____

Primary Care Provider	PCP Phone Number

Do you see any specialist: ☐ Yes ☐ No

Specialist Name	Specialty	Specialist Phone Number

Please check any of the following that apply to your childhood or adolescence:

_____ Unhappy Child _____ Family Problems _____ School Problems

_____ Emotional/Behavioral Problems _____ Alcohol Abuse _____Drug Abuse

_____ Medical Problems _____ Legal Problems _____ Physical Abuse

_____ Sexual Abuse _____ Emotional Abuse _____ Other:_____

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Family History (Check all that apply):

	Mother	Father	Siblings
Alcohol/Drug Use			
History of Completed Suicide			
History of Mental Illness, such as:			
Depression			
Bi-Polar			
Schizophrenia			
Anxiety			
Attention Deficit/Hyperactivity			
Learning Disability			
Incarceration			
Other			

Check the following words you would use to describe yourself:

Intelligent	Confident	Worthwhile	Ambitious
Sensitive	Loyal	Trustworthy	Evil
Full of Regrets	Worthless	A Nobody	Useless
Crazy	deviant	Unattractive	Ugly
Considerate	Unlovable	Inadequate	Naïve
Confused	Hardworking	Incompetent	Stupid
Attractive	Persevering	In Conflict	Honest
Suicidal	Can't Make a Decision	Memory Problems	

What are the goals you would like to work on while you are here at treatment?