



			Yes	No
			Yes	No
			Yes	No

Has how you were treated and raised as a child had more of a positive or negative effect on your personality?                      Positive                      Negative

If you circled negative, please explain:

Are there any traumatic events that have influenced your life?

Were you ever abused or mistreated?                      Yes                      No

If yes, please circle all that apply:                      \_\_\_\_\_ None

Sexual Abuse	Physical Abuse	Emotional Abuse	Neglect
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Was the Department of Children and Families (DCF) ever involved with your family as a child?

Yes    No

Has anyone in **your family** been diagnosed with any of the following?                      \_\_\_\_\_ None

Depression	Learning Disability	Obsessive Compulsive Disorder	Bipolar Disorder
Schizophrenia	Intellectual Disability (MR)	Substance Abuse/Alcoholism	Autism
Anxiety	Conduct Disorder	Personality Disorder	ADHD/ADD
Other			

Current Family History:

Have you ever been married?                      Yes                      No                      How many times? \_\_\_\_\_

Spouse Name	Date Married	Date Separated/Divorced

Who do you currently live with?

\_\_\_\_\_

Do you currently have a boyfriend/girlfriend?                      Yes    No

How long?

\_\_\_\_\_



Medical History:

Place an "X" in the appropriate range if you have suffered from any of the following: \_\_\_\_\_ None

Medical Disorder	As a child/teenager	As an adult
Chronic Ear Infections		
Cancer		
HIV/AIDS		
Heart Attack		
Concussion		
Seizure/Epilepsy		
Broken Bones		
Chronic Stomach Problems		
Asthma		
Meningitis		
Multiple Sclerosis		
Thyroid Condition		
High Blood Pressure		
Diabetes		
Other		

Have you ever had surgery? Yes No If Yes, explain:

Any visual difficulties? Yes No Do you wear glasses or contacts? Yes No  
 Any hearing difficulties? Yes No Do you wear a hearing aid? Yes No

Circle any mental health disorder in which **you** have been diagnosed: \_\_\_\_\_ None

Depression	Learning Disability	Obsessive Compulsive Disorder	Bipolar Disorder
Schizophrenia	Intellectual Disability (MR)	Substance Abuse/Alcoholism	Autism
Anxiety	Conduct Disorder	Personality Disorder	ADHD/ADD
Other			

Please list any prescription medications that you currently use: \_\_\_\_\_ None

Medication	For What?	Doctor Who Prescribed?

Mental Health History:

Circle any of the following which have been an issue for you over the past year:

Getting to work/school on time	Fidgeting	Eating too little/too much	Getting along with people
Nervousness/Anxiety	Sad most of the day	Suicidal thoughts	Paying attention
Poor communication	Restlessness	Emotional control	Anger management
Self-esteem	Not thinking before I act	Self-injury	Organization
Easily distracted	Talk too much	Risky/Illegal behavior	Obsessions
Irritability	Loss of interest in normally enjoyable activities	Phobia with _____	
Excessive spending	Sleep too much/too little	Vomit after eating	Hallucinations
Bizarre thinking	Hoarding	Unproductive rituals	Forgetfulness
Few close friends	Procrastination	Test Anxiety	Panic attacks

Have you been to counseling before?      Yes      No      If so, when? \_\_\_\_\_  
 Who was the therapist? What were you treated for?

Have you ever received inpatient hospitalization for a mental health issue?      Yes      No  
 If yes, explain each placement.

Have you ever attempted suicide? Yes      No      How many times? \_\_\_\_\_  
 Please explain each attempt:

Drug and Alcohol Use:

Please circle all substances you have used in the past:      \_\_\_\_\_ None  
 Alcohol, PCP (angel dust), marijuana, amphetamines (speed), cocaine, crack cocaine, hallucinogens (acid, mushrooms), ecstasy, methamphetamine (meth), opium, heroin, sleeping pills, pain killers  
 Please include last use for any items circled

\_\_\_\_\_

\_\_\_\_\_

What substances do you currently use? How often?

Have you ever been treated for drug or alcohol abuse?      Yes      No  
 If so, when and where?

Have you ever lost a job or relationship because of substance abuse?      Yes      No  
 If so, when and what happened?

Have you ever been in legal trouble for drug or alcohol abuse?      Yes      No  
 If so, when and what happened?

Legal History:

Have you ever been in trouble with the law? Yes No

If so, when and what happened?

Offense	Date	Length of jail time, probation, or fine

Educational History:

Did you attend Preschool? Yes No If so, where? \_\_\_\_\_

Please list all of the schools you have attended.

School	City, State	Ages or Years or Grades Attended

Did you graduate high school? Yes No When did you graduate? \_\_\_\_\_

If you have not graduated, when do you expect to? \_\_\_\_\_

Did you graduate with a standard diploma? Yes No

If you did not graduate high school, did you get a GED? Yes No

Do you intend to go to college? Yes No

Have you attended any college? Yes No Major \_\_\_\_\_

Did you graduate from college? Yes No Degree \_\_\_\_\_

If you attended college but did not finish, please explain.

Did you have an Individualized Education Program (IEP)/504 Plan? Yes No

Were you in special education/Exceptional Student Education (ESE) in school? Yes No

If so, which grade were you in when you began special education? \_\_\_\_\_

Circle any disability that you were placed in ESE/special education for:

Reading learning disability	Math learning disability	Writing learning disability	Speech impaired
Hearing impaired	Visually impaired	Emotional disturbance	Mental retardation
Autism/Asperger's	Traumatic Brain Injury	Medical impairment	Other

What types of accommodations or help with school do/did you receive (mark all that apply)?

Extended time on tests	Tests taken in a quiet space	Tests taken in small group	Additional time to complete assignments
Intensive Reading	Intensive Mathematics	Social-Communication Classroom	Behavior Unit Classroom
Intensive English/Language Arts	Speech or Language Therapy	Occupational Therapy	Physical Therapy
Shortened Assignments	Subjects taught below grade level curriculum	Exempt from state-wide standardized tests	Functioning Living Skills Classroom

Did you ever have to repeat a grade? Yes No If so, what grade(s)? \_\_\_\_\_  
 Did you ever get in trouble at school? Yes No If so, when did it start? \_\_\_\_\_  
 Did you ever get detentions? Yes No Did you ever get suspended? Yes  
 No  
 What types of behaviors did you get in trouble for at school?  
 Did you ever get expelled from school? Yes No What grade were you in? \_\_\_\_\_  
 If so, why were you expelled?

Please list any after school activities that you participated in (e.g., clubs, sports)

Daily Living:

Can you drive a car?	Yes	No
Do you have a driver's license?	Yes	No
Do you own/lease your own car?	Yes	No
Can you do your own laundry?	Yes	No
Can you calculate change?	Yes	No
Can you do your own grocery shopping?	Yes	No
Can you cook for yourself or your family?	Yes	No
Can you bathe and dress yourself without help?	Yes	No

Financial History:

Have you ever filed for bankruptcy? Yes No  
 If yes, please explain.

Describe your current debt:

\_\_\_\_\_  
 You are financially dependent on (circle all that apply): Self Spouse Parents/Family  
 SSI/SSID Other:

\_\_\_\_\_  
 Do you own your home or pay rent?  
 Are you able to pay your bills on time? Yes No

