Do you gamble? 0 No 0 Yes

If "Yes," How many times per month? _

What percentage of your monthly income do you spend per month on gambling? _

Please complete the following regarding current and/or past alcohol & drug use/abuse:						
Type of Drug	Currently Using	Past Use	Never Used		Frequency/Type of Use & Resulting Problems	
Alcohol						
Marijuana						
Methamphetamines						
Cocaine						
Hallucinogens						
Other Illegal Drugs						
Abuse of Prescription						
Drugs						
Abuse of OTC Medication						

Do you use tobacco? 0 No 0 Yes

Do you use caffeine? 0 No 0 Yes

Please check the items below which describe medical symptoms you have had in the past 12 months:

Persistent Cough 0 Shortness of Breath 0 Heart Disease

High Blood Pressure 0 Abnormal Heartbeat 0 Balance Problems/Falling

Severe/Persistent Headaches

Numb/Weak Limbs/Body

Joint Aches/Pains

Trouble Urinating

Stomach/Abdominal Pain

Change/Trouble w/ Hearing

O Loss of Consciousness

Muscle Weakness

Bruise Easily

Urinary Infection

Vomiting

Change in Sense of Smell

Seizures

Muscle Pain

Kidney Infection/Disease

Liver Disease

Change/Trouble w/ Vision

Sore/Swollen Neck/Gland

Speech Problem

Thyroid Disease

Feeling Clumsy/Dropping Things 0 Pain in Mouth/Trouble Swallowing

Voice Problems 0 Pain/Lumps/Drainage from Breasts
Signature of Client/Guardian of Client:______________________
Date:_____________

Office Use

Therapist's Signature: _

Referred for physical exam? 0 No

Referred for psychiatric eval? 0 No

Client willing to accept referral? 0 No
Date Reviewed: -_____/ /

O Yes If Yes, to whom? _________________

O Yes If Yes, to whom? _________________

O Yes

Please complete the following regarding you current medications:			
Name of Medication or Herbs	When Prescribed	Dosage	Reason

MEDICAL INFORMATION
Client Name: ________________________________
Soc. Sec. #: _
DOB:
/ /
The reason I am here today is: _
Please check **the items below which apply to you in the past six months:**

Changes in Appetite
Loss of Weight
Weight Gain
Binge or Purge
Worried About Your Weight
Trouble Sleeping
Restless Difficulty Sitting Still
Thoughts of Suicide
Other (specify): '-- _
High Energy
Low Energy
Difficulty Concentrating
Racing Thoughts
Sad or Depressed
Crying Spells
Loss of Interests
Self Hurt/Harm

0 Worried About Your Appearance
0 Forgetfulness or Memory Problems
0 Anger
0 Verbal Fighting
0 Physical Fighting
0 Sexual Problems
0 Anxious or Nervous
0 Feel Like Mind Playing Tricks

Have you ever had counseling/therapy or medication for any of the above?
If "Yes, "Where? ___________________________ When?____________________
Have you been hospitalized for any of the above? O No O Yes If "Yes," Reason? _
If "Yes, " Where? __________________________ When? ____________________ What Doctor? _______________

O No O Yes
With Whom? _
Do you have a Psychiatric Advance Directive? D No D Yes (Please provide a copy to your therapist)
When did you last have a complete physical exam? __ / __/ __ Primary Physician: _
How do you rate your overall health? D Excellent O Good O Fair O Poor
What is your main concern about your health? _

Any other medical problems? Please describe: _
Do you have any allergies or drug sensitivities? Please describe; _

Imagine Counseling Services, PC

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Fax: (402) 934-9853

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Omaha, NE 68137

Have you ever:	YES	NO
Thought you should cut down on your drinking or drug use?		
Been annoyed when others have asked you about your drinking or drug use?		
Felt guilty about how much you drink or used illegal drugs?		
Had a drink/used drugs to get going or treat a hangover?		
Had anyone complain about your drinking/using?		
Gotten in trouble with the law, family members, or friends when you drink/use?		
Do you usually get into trouble when you drink/use?		