

Name: _____ Date: _____
 List any allergies you have: _____ None
 Primary Care Physician: _____ Address: _____
 City: _____ State: _____ ZIP: _____
 Primary Care Physician's phone number: (____) _____
 Date of your most recent physical examination: _____

What kind of problem brings you to Horizons?

List all current medications and dosages:

Name of Medication	Dosage	Name of Prescribing Doctor	When did you start taking it?

List all current or past health problems, and any major operations:

Current	Past

List all therapists you have seen, and dates you saw them:

List any substance abuse treatment or inpatient psychiatric treatment you have had, and the dates:

Please indicate which of these substances you currently use:

Substance	Amount used	How many times per month do you use it?
<input type="checkbox"/> Cigarettes		
<input type="checkbox"/> Alcohol		
<input type="checkbox"/> Marijuana		
<input type="checkbox"/> Cocaine or crack		
<input type="checkbox"/> Heroin		
<input type="checkbox"/> Pills not prescribed for me		
<input type="checkbox"/> LSD		
<input type="checkbox"/> Other (please list):		

Please indicate if you are having any of the following problems, or if you had them in the past

	I have this now	I had it in the past
Difficulty falling asleep or staying asleep	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>
Change in appetite, weight loss, or weight gain	<input type="checkbox"/>	<input type="checkbox"/>
Frequent crying	<input type="checkbox"/>	<input type="checkbox"/>
Thoughts of killing or hurting myself	<input type="checkbox"/>	<input type="checkbox"/>
Attempts to kill or hurt myself	<input type="checkbox"/>	<input type="checkbox"/>
Problems concentrating	<input type="checkbox"/>	<input type="checkbox"/>
Periods of daily sadness lasting more than two weeks	<input type="checkbox"/>	<input type="checkbox"/>
Little or no interest in sex	<input type="checkbox"/>	<input type="checkbox"/>
I feel tired almost every day	<input type="checkbox"/>	<input type="checkbox"/>
Problems remembering things	<input type="checkbox"/>	<input type="checkbox"/>
Periods of time in which I felt so good or so hyper that other people thought I was not my usual self or I was so hyper that I got into trouble	<input type="checkbox"/>	<input type="checkbox"/>
I startle easily	<input type="checkbox"/>	<input type="checkbox"/>
Can't stop remembering upsetting past events	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty controlling my temper	<input type="checkbox"/>	<input type="checkbox"/>
I physically hurt other people	<input type="checkbox"/>	<input type="checkbox"/>
I break things sometimes	<input type="checkbox"/>	<input type="checkbox"/>
I worry a lot	<input type="checkbox"/>	<input type="checkbox"/>
Panic attacks or anxiety attacks	<input type="checkbox"/>	<input type="checkbox"/>
Feeling that I or my surroundings are unreal	<input type="checkbox"/>	<input type="checkbox"/>
Made myself throw up in order to lose weight	<input type="checkbox"/>	<input type="checkbox"/>
Used laxatives or exercised excessively to lose weight	<input type="checkbox"/>	<input type="checkbox"/>
I often feel like I am an outsider	<input type="checkbox"/>	<input type="checkbox"/>
Sexual problems	<input type="checkbox"/>	<input type="checkbox"/>
Worry that something is wrong with my body	<input type="checkbox"/>	<input type="checkbox"/>
Frequent arguments with the people I live with	<input type="checkbox"/>	<input type="checkbox"/>
Other (please list):		
Reviewed by _____ Date _____		