**Austin B, Imus D.O.**

**1433 N. 1075 W. Suite 120**

**Farmington, Utah 84025**

**Phone: 801-923-8044**

**Fax: 801-855-5891**

**New Patient Evaluation Form**

Please fill out the following confidential intake form prior to your first appointment with Dr. Imus. By answering these questions accurately and thoughtfully, you will be helping set the therapeutic process in motion. If you are uncomfortable answering any of these questions, please feel free to leave them blank; we can discuss them in more detail at our initial evaluation.

**PATIENT IDENTIFICATION:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: \_\_\_\_\_\_\_\_\_\_ Preferred

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about Dr. Imus ?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list two Emergency Contacts:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_

**Name of Insurance Company if you plan to use Insurance**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Polcy Holder’s Name and relation to you:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s SS#:\_\_\_\_\_\_\_\_\_\_\_

Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of Plan: PPO HMO Indemnity EAP or Other: \_\_\_\_\_\_\_\_\_\_\_\_

Phone number for verification of benefits/eligibility (on back of card): (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address to send Billing:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(1)**

**PURPOSE OF APPOINTMENT:** (In your own words, please describe the problems you are currently experiencing which have prompted you to seek treatment)

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**PRESENTING SYMPTOMS:** Please check any symptoms that may pertain to you:

\_\_\_**Depressed or sad mood**

**\_\_\_Difficulty enjoying usual activities**

**\_\_\_Unintentional weight loss or weight gain**

**\_\_\_Sleeping too much or not enough**

**\_\_\_Feeling agitated or sluggish**

**\_\_\_Lacking energy/always tired**

**\_\_\_Feeling guilty or worthless**

**\_\_\_Poor focus and concentration**

**\_\_\_Thoughts of death or suicide**

**\_\_\_Inflated self-esteem**

**\_\_\_Decreased need for sleep or going for days without sleeping**

**\_\_\_Excessive talking**

**\_\_\_Racing thoughts**

**\_\_\_Feeling highly distractible**

**\_\_\_Try to do or accomplish way too much in a day**

**\_\_\_Impulsive behavior**

**(2)**

**\_\_\_Seeing or hearing things that may not be real**

**\_\_\_Feeling like people are watching you or out to get you**

**\_\_\_Often tense or unable to relax**

**\_\_\_Excessive worrying**

**\_\_\_Panic Attacks**

**\_\_\_Afraid/unable to leave home**

**\_\_\_Extreme unreasonable fears**

**\_\_\_Intense fear of social situations**

**\_\_\_Cannot prevent repetitive thoughts**

**\_\_\_Cannot prevent repetitive behaviors**

**\_\_\_Intrusive, upsetting memories of past events**

**\_\_\_Always on guard or never feel safe**

**\_\_\_Body overreacts to "stress"**

**LIFE PROBLEMS THAT CURRENTLY AFFECT YOU:**

**\_\_\_Problems within my family**

**\_\_\_Problems among my friends/community**

**\_\_\_Educational problems**

**\_\_\_Occupational/Job problems**

**\_\_\_Housing problems**

**\_\_\_Financial/Economic problems**

**(3)**

**\_\_\_Problems with the law, legal system**

**\_\_\_Destructive/violent thoughts or behaviors**

**\_\_\_Attempts to hurt, harm, or mutilate self**

**\_\_\_Anger outbursts**

**\_\_\_Discipline problems at work**

**\_\_\_Careless, high-risk behavior**

**PAST PSYCHIATRIC HISTORY:**

Have you ever been hospitalized for psychiatric reasons? Circle YES or NO. If yes, please elaborate:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever seen a psychiatrist on an outpatient basis? Circle YES or NO. If yes, please give details:

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Have you ever received counseling or psychotherapy in the past? Circle YES or NO. If yes, please elaborate:

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Which psychiatric medications have you taken in the past and what were the benefits and/or side effects you

experienced?

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**(4)**

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Are you currently taking any psychiatric medications? Circle YES or NO

If yes, please list all current medications along with dosages and prescribing physician name:

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**GENERAL MEDICAL HISTORY:**

Do you have a Primary Care Physician (PCP)? Circle YES or NO

If yes, please list name of PCP and his or her phone # and address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Date of Last Physical Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Lab work\_\_\_\_\_\_\_\_\_\_\_\_

Do you suffer from any of the following general medical problems? Please check all that apply:

□ Chest Pain

□ Diabetes

□ Thyroid Disease

□ Hormone Problems

□ Fever or Sweats

□ Blood Disease

□ Anemia

□ Bruise Easily

□ Nose Bleed

□ Liver Disease

□ Jaundice

□ Hepatitis

□ Stomach Ulcers

□ Nausea/Vomiting

□ Unusual Diet

**(5)**

□ Abdominal Pain

□ Skin Rash

□ Skin Ulcer/Lesion

□ Sexually Transmitted Disease

□ HIV

□ Sexual Difficulties

□ Gynecological Problems

□ Prostate Problems

□ Glaucoma

□ Visual Spots

□ Double Vision

□ Hearing Problems

□ Speaking Problems

□ Memory Problems

□ Early Fatigue

□ Daytime Sleepiness

□ Difficulty Sleeping

□ Concentration Problems

□ Sinus or Nasal Problems

□ Recurrent Infection of any kind

□ Depressed Immune System

□ Heart Attack

□ Coronary Artery Disease

□ Rheumatic Fever

□ High/Low Blood Pressure

□ Stroke

□ Heart Palpations

□ Heart Surgery

□ Pace Maker Implant

□ Cancer

□ Lung Disease

□ Asthma

□ Emphysema

□ Chronic Cough

**(6)**

□ Bronchitis

□ Pneumonia

□ Tuberculosis

□ Shortness of Breath

□ Neurological Disorders

□ Seizures

□ Epilepsy

□ Fainting

□ Vertigo/Dizziness

□ Motor Difficulties

□ Serious Head Injury

□ Recurring Headaches

□ Arthritis

□ Muscle Cramps

□ Muscle Stiffness

□ Weakness

□ Tremors

□ Numbness

□ Difficulty Walking

□ Uncontrolled Movements

□ Kidney Disease

- 5 -

Do you take any prescription medications for your general medical problems? Circle YES or NO. If yes, list:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you take over-the-counter medications, herbal or dietary supplements, or vitamins? Circle YES or NO

If yes, please list:

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**(7)**

Are you allergic to any medications? Circle YES or NO. If yes, please list medications and allergic reactions:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you undergone any surgical procedures? Circle YES or NO. If yes, please list all surgical procedures:

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Do you have any problems with chronic physical pain or fibromyalgia? Circle YES or NO

If yes, please describe and rate your average pain level using the scale below:

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Circle one 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (worst)

Have you ever suffered a severe head injury with loss of consciousness or a concussion? Circle YES or NO

If yes, please describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**ALCOHOL, DRUG AND TOBACCO USE:**

**ALCOHOL:** Would you say you ❑ are a non-drinker? ❑ are a social drinker? ❑ are a regular drinker?

❑ have a drinking problem? ❑ are an alcoholic? Regardless of the box you checked, please describe the frequency of your alcohol use and what kind of alcohol and how much you drink, including date of last use:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you had any problems related to use or undergone treatment for use? Circle YES or NO

If yes, please describe (Legal, Financial, Health, or Relationship problems):

**(8)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DRUG AND / OR PRESCRIPTION DRUG USE:** Check if none \_\_\_\_

Would you say you ❑ are a recreational drug user? ❑ have a drug problem? ❑ have a drug addiction?

Please checkmark which substances below you regularly use:

\_\_ Benzodiazepines (Klonopin, Valium, Xanax, Ativan)

\_\_ Caffeine

\_\_ Tobacco

\_\_ Marijuana/THC

\_\_ Cocaine/Crack

\_\_ Designer Drugs (such as Club Drugs: G, X)

\_\_ Hallucinogens (LSD, Mushrooms)

\_\_ Inhalants (Gasoline, Glue, Aerosol)

\_\_ Methamphetamines (Speed, Ice, Adderall)

\_\_ Opiates/Methadone (Vicodin, Oxycontin, Heroin)

\_\_ Prescription Pills (please list):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Which of these have you experienced related to your drug use? ❑ Blackouts ❑ Bad reactions ❑ Withdrawal symptoms ❑ Cravings ❑ Overdoses ❑ Tolerance (“Could not get high no matter how much I used”)

❑ Preoccupation (Spent lots of time finding and using substance) ❑ Failed attempts to cut down or control use ❑ Detoxification in a hospital ❑ Other problems:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**SOCIAL HISTORY:**

Where were you born and where did you grow up?

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Did your parents stay together while you were growing up? Circle YES or NO

If no, how old were you when they separated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father's occupation while you were growing up: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(9)**

Mother's occupation while you were growing up: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you describe your current relationship with your father? Circle GOOD, AVERAGE or BAD

How would you describe your current relationship with your mother? Circle GOOD, AVERAGE or BAD

How many siblings do you have? None \_\_\_\_\_ Brothers \_\_\_\_\_\_ Sisters\_\_\_\_\_\_

- 7 -

How would you describe your relationship with your siblings? GOOD, AVERAGE, or BAD and describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Were there any complications at your birth (premature birth, major medical problems?) Circle YES or NO

If yes, please describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any problems in your early development (learning to walk, talk, read, etc)? Circle YES or NO

If yes, please describe:

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Did you suffer from any major illnesses / injuries while you were growing up? Circle YES or NO

If yes, please describe:

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Are you/were you a victim of any form of abuse?

Physical Abuse: Circle YES or NO. If yes, please describe and specify age of occurrence:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Sexual Abuse: Circle YES or NO. If yes, please describe and specify age of occurrence:

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**(10)**

Emotional/Verbal Abuse: Circle YES or NO. If yes, please describe and specify age of occurrence:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What is the highest educational degree you have obtained? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What kinds of jobs and/or professions have you had in the past?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you currently employed? If yes, where?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently involved in a romantic relationship? Circle YES or NO

If yes, what is your partner's first name and occupation?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you been together? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you describe your relationship? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been involved in any previous significant intimate/romantic relationships? Circle YES or NO

If yes, please describe briefly:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have any children? Circle YES or NO

If yes, what are their names & ages?

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What are some things you enjoy doing in your spare time? (hobbies, interests, etc)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**(11)**

Have you ever been convicted of any crimes, incarcerated in prison, or placed on probation? Circle YES or NO

If yes, please describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**FAMILY HISTORY:**

Is there any family history of mental illness or substance abuse among your blood relatives? Circle YES or NO

If yes, please describe as below:

Father’s Side:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Mother’s Side:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**ADDITIONAL INFORMATION YOU WOULD LIKE DR. Imus TO KNOW:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*Thank you for taking the time to fill out this confidential form accurately and thoughtfully*

***(12)***