

Initial visit

Name: _____

Date: _____

SOCIAL HISTORY & CURRENT HABITS:

Married Single Widowed Separated Divorce

Occupation _____ FT PT Retired Unemployed

Level of education _____

Hobbies, recreational activities, interests, sports & level in which you participate

Please check any of the habits listed below which apply to you now or in the past

- Coffee Cups per day _____
- Tobacco # of cigarettes per day _____
- Marijuana Use per day / week _____
- Alcohol Use per day / week _____
- Crack/Cocaine Use per day / week _____
- Heroin Use per day / week _____
- Other _____

Age started	Age Quit

Please indicate if you would like help with any of the following:

- Quitting smoking
- Stopping/reducing alcohol use
- Stopping/reducing drug use
- Nutrition
- Weight loss
- Exercise
- Sexual function
- Stress relaxation
- Feelings of depression

FEMALES:

Age menses started _____ Date of last menstrual period _____

Interval of periods _____ Duration of flow (days) _____

Amount of flow: Heavy for _____ days, Medium for _____ days, Light for _____ days, Spotting for _____ days

Clots _____ Cramping _____

Current method of contraception _____

Pertinent contraception history _____

Date of menopause (approx OK,) start _____ end _____ any bleeding since _____

PREGNANCIES:

Are you currently pregnant? _____ Total pregnancies _____ Living _____ Ectopic _____

Miscarriages _____ Induced Abortions _____

Do you have any additional concerns or conditions that you would like me to be aware before we begin your session?
