To help us provide the best treatment for you, please answer the questions on this form and return it to the clinic as soon as possible to assist us with scheduling your first appointment.

- You may also submit Online via S**ecured Email: behavioralhealth@yumaregional.org** or **Faxing: 926-336-2490**

Name: _____ Date: _____
Address: _____
Phone: _____ Email: _____
DOB: _____ Sex: _____
Primary Physician: _____ Phone: _____

Current Therapist: _____ Phone: _____

Complaint

What is your major complaint? _____
Start Date: _____ Have you previously suffered from this complaint? _____
Previous therapist(s) seen for complaint: _____
Previous treatment for complaint: _____
Aggravating Factors: _____
Relieving Factors: _____

Current Symptoms (Check All That Apply)

☐ Anxiety	☐ Hallucinations	☐ Irritability	☐ Risky Activity
☐ Appetite Issue	☐ Loss of Interest	☐ Panic Attacks	■ Sleep Changes
☐ Avoidance	☐ Excessive Energy	☐ Racing Thoughts	☐ Suspiciousness
☐ Crying Spells	☐ Fatigue	☐ Guilt	
☐ Depression	☐ Impulsivity	☐ Libido Changes	

Medical History

Exercise Frequency: _____ Exercise Type (s): _____
Allergies: _____
What medications are you currently using? _____
Previous diagnoses/mental health treatment: _____
Previously treated by: _____
Previous medications: _____
Dates treated: _____
Previous medical conditions: _____
Previous surgeries: _____

To help us provide the best treatment for you, please answer the questions on this form and return it to the clinic as soon as possible to assist us with scheduling your first appointment.

- You may also submit online via Secured Email: behavioralhealth@yumaregional.org or Faxing: 926-336-2490

Family History

Were you adopted?_____If yes, at what age? _____Foster care? _____How long?_____
How is your relationship with your mother? _____
How is your relationship with your father? _____
Siblings and their ages: _____
Are your parents married?_____Divorced?_____
Did your parents remarry?_____ If yes? How old were you? _____
If a patient is a minor under 18 years old and parents are divorced, who is medical decision maker?
_____
Who raised you? _____Where did you grow up? _____
If patient is a minor under 18 years old, school attending? _____grade _____
special education?_____
Family member medical conditions:_____
Family member mental conditions:_____
Treated with medication?_____
Medications:_____

Early Development

How often did you move and where? _____
How old were you when you left home? _____
Have any immediate family members died? _____Who? _____
Have any completed suicide?_____Who? _____
Describe any neglect you suffered, and by whom:_____
Trauma suffered and by whom:_____
Abuse suffered and by whom:_____
Highest education level completed:_____Date completed and location:_____
Have you ever served in the military?_____If yes, where?_____
Date of service: _____Highest Rank achieved _____

Present Situation

Work: ☐Full-time ☐Part-time ☐Student ☐Unemployed ☐Disabled ☐Retired
Are you married?_____If yes, date of marriage:_____
Are you divorced?_____If yes, date of divorce:_____
Prior marriages?_____If yes, how many?_____
What are your preferred pronouns? _____

To help us provide the best treatment for you, please answer the questions on this form and return it to the clinic as soon as possible to assist us with scheduling your first appointment.

- You may also submit online via Secured Email: behavioralhealth@yumaregional.org or Faxing: 926-336-2490

How is your relationship with your partner?_____
Do you have children? _____Dates of Birth:_____
How is your relationship with your child(ren)?_____
List anyone else who lives with you: _____
Are you a member of a religion/spiritual group? _____
What is your level of involvement? _____
Have you ever been arrested? _____When and why?_____
Are you under court ordered treatment? _____

Have You Ever Tried the Following? (Check All That Apply)

■ Heroin	☐ Methamphetamines	☐ Cocaine	☐ Stimulants (Pills)
☐ Ecstasy	☐ Methadone	☐ Tranquilizers	☐ Pain Killers
☐ Tobacco	☐ Marijuana	☐ Hallucinogens	☐ Alcohol

If yes to any, list frequency/dates of use:_____
Have you ever been treated for drug/alcohol abuse? ___If yes, when? _____
For which substances?_____
Do you smoke cigarettes? _____If yes, how many per day? _____
Do you drink caffeinated beverages? ____If yes, how many per day? _____
Have you ever abused prescription drugs?_____If yes, which ones?_____

Anything Else You Want the Doctor to Know

_____
_____
_____
_____
_____
_____
_____
_____

Signature: _____ **Date:** _____

Legal Guardian Name: _____ **Signature:**_____ **Date:**_____