Creating Connections Counseling Services

Take-Home Information

1. Medical information:
   A. Current health concerns: _____
   _____
   _____

   B. Date of last physical examination: _____ Performed by Dr. _____
   Results/concerns discussed: _____
   _____
   _____

   C. Current medications:

Name	Dosage	Start Date	Side Effects

   D. Prescribing doctor: _____ Location: _____

   E. Primary care physician: _____ Phone: _____

2. Substance abuse history:

Substance	Age at First Use	Last Time Used	Currently Using?	Longest Time Able to Remain Abstinent

   A. Consequences of substance abuse (circle all that apply):

Anger	Sexual Problems	Suicidal or Homicidal Thoughts or Actions
Sadness	Conflicts in Relationships	Loss of Job or Financial Problems
Depression	Legal Problems	Blackouts or Withdrawal Symptoms

   Other: _____

3. Spiritual orientation and description of your faith journey: _____
   _____
   _____
   _____

4. Previous counseling, psychotherapy or psychiatric treatment. Please include: provider name(s), dates, locations, focus of treatment, results (completed goals/program, improved, dropped out, moved away, other). If it was helpful, how was it helpful? If it was a bad experience, what happened?
   _____
   _____
   _____

_____ _____ _____

Patient Name Signature Date