WELCOME!

This is to confirm your appointment at our MK Plus office on

______________________, __________________ at___________ with
Day Date Time

____.
Provider Name

Our office is located at:
31 Cambridge Lane
Suite A
Newtown, Pennsylvania 18940
(local landmarks include Citizen's Bank. We are located on the 2nd Floor)

Please do not hesitate to call us at **215-968-5151** should you require directions to our office. If you prefer, you can print directions from our website www.mkplusnewtown.com

Prior to your visit, please review and complete the enclosed information and bring it with you to your appointment. Feel free to call our office at 215-968-5151 should you have any questions on completion of the packet prior to your visit.

If for any reason you need to cancel or reschedule your intake appointment, we ask that you provide our staff with as much notice as possible. Please call our office 215-968-5151 and leave a message in our general mailbox and we will take care of notifying the provider.

We look forward to meeting you!

Name: ____ **Date**: __________________________

Address: ____ **Birthdate**: _______________________

____ **Home phone #**: ____________________

Cell phone #: _____________________

PRESENTING CONCERN:

Please describe the main difficulty that has brought you to see me:

____

____

REFERRAL SOURCE:

Who referred you to our office? ____________________________________

Can we have your permission to thank them for the referral? ______________________________

TREATMENT:

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

(__) No (__) Yes If yes, please indicate:

When?	From whom?	For what?	With what results?

Have you ever taken medications for psychiatric or emotional problems?

(__) No (__) Yes If yes, please indicate:

When?	From whom?	Which medications?	For what?	With what results?

EDUCATIONAL TRAINING

Where? [School]	From when?	To When?	Accomplishments [Degrees, Special Classes]

EMPLOYMENT/MILITARY EXPERIENCE

Where?	From when?	To When?	Comments about the experience

RELATIONSHIPS IN YOUR FAMILY OF ORIGIN. Please describe the following:

Your parents' relationship with each other:

____

____

____

Your relationship with each parent and with other adults present:

____

____

____

Your parents' physical health problems, drug or alcohol use, and mental or emotional difficulties:

____

____

____

Your relationship with your brothers and sisters, in the past and present:

____

____

____

ABUSE HISTORY

(__) I was not abused in any way. (__) I was abused. If you were abused, please describe below:

Your age	Kind of Abuse	By whom?	Effects on you?	Whom did you tell?	Consequences of telling?

PRESENT RELATIONSHIPS

How do you get along with your present spouse or partner?____ How do you get along with your children?____ Your important friends, past and present:

Names	Good parts of relationship	Bad parts of relationship

CHEMICAL USE

Have you ever felt the need to cut down on your drinking? (__) No (__) Yes

Have you ever felt annoyed by criticism of your drinking? (__) No (__) Yes

Have you ever felt guilty about your drinking? (__) No (__) Yes

Have you ever taken a morning "eye-opener"? (__) No (__) Yes

How much beer, wine, or hard liquor do you consume each week, on the average? __________________________________

Are there times when you drink to unconsciousness, or run out of money as a result of drinking? ______________________

How much tobacco do you smoke or chew each week? ____

Have you ever used inhalants ("huffing"), such as glue, gasoline, or paint thinner? (__) No (__) Yes If yes, which and when?

____

Which drugs (not medications prescribed for you) have you used in the last 10 years? _______________________________

____

Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects and so forth ____

____

Have you ever injected drugs? ______ Yes _______No

Ever shared needles? ______ Yes _______No

Have you had HIV testing in the last 6 months? ______ Yes _______No

If yes, results: ____

At the present time, are there any other medical or physical problems you are concerned about?

____

PAST MEDICAL HISTORY

Starting with your childhood up to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalization, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had.

Age	Illness/diagnosis	Treatment Received	Treated by	Result

Describe any allergies you have.

To what?	Reaction you have	Allergy medications you take

List all medications, drugs or other substances you take or have taken in the last year—prescribed, over-the-counter vitamins, herbs and other

Medication/drug	Dose (how much)?	Taken for	Prescribed and supervised by

MEDICAL CAREGIVERS

Your current family or personal physician or medical agency:

Name	Specialty	Address	Phone #	Date of last visit

Other physicians treating you at present or in last five years:

Name	Specialty	Address	Phone #	Date of last visit

HEALTH HABITS

What kinds of physical exercise do you get?

____

How much coffee, cola, tea or other sources of caffeine do you consume each day?

____

Do you try to restrict your eating in any way? How? Why?

____

Do you have any problems getting enough sleep?

____

FOR WOMEN ONLY

At what age did you start to menstruate (get your period):
____

Menstrual period experiences:

How regular are they? ____

How long do they last? ____

How much pain do you have? ____

How heavy are your periods? ____

Other experiences during periods? ____

Please list all of your pregnancies:

Your age	What happened with this pregnancy			Problems?
	Miscarriage	Abortion	Child born	

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper:____

____