**PERSONAL INFORMATION**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex:\_\_\_\_ Birthplace:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity (optional): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Religious/Spiritual Faith: (optional) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexual Orientation (Optional): H/L/G/B/T \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Policyholder Information (if different from patient):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name  | Date of Birth | Social Security No. | Relationship to Patient | Address (if different from patient) | Name of Employer |

**CURRENT SYMPTOMS (Check All That Apply)**

* Anxiety
* Depression
* Hallucinations
* Appetite Issues
* Excessive Energy
* Impulsivity
* Panic Attacks
* Suspiciousness
* Avoidance
* Fatigue
* Irritability
* Racing Thoughts
* Crying Spells
* Guilt
* Libido Changes
* Risky Activity
* Loss of Interest
* Relationship Problems
* Work Problems
* Sleep Change

**CURRENT MEDICATIONS OR OVER THE COUNTER PRODUCTS for ANY REASON**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Medication** | **Dosage (mg)** | **How often taken per day** | **Reason for Medication** |
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**Neuropsychiatric History**

**HAVE YOU EVER EXPERIENCED HEAD TRAUMA? Yes\_\_\_\_\_\_\_NO\_\_\_\_\_\_\_\_ If yes, please explain:**

List ***moving vehicle accident(s) at any time in your life that resulted in personal injury or death of someone.***

Have you suffered neurological disorders that affect you mentally? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Undergone a sleep study?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Results:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Psychiatric History:**

Psychiatrist: List names of previous Psychiatrist, Dates of Treatment, and Reason for Treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychotherapy: List Names of Previous Therapist, Dates of Treatment, and Reason for Treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had marital, relational, or family treatment: Yes \_\_\_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_\_\_\_

\*Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prior Psychiatric Hospitalization(s): Yes\_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Ingestion History: Dietary and Other**

Amount of Caffeine consumption (tea, coffee, soda, chocolate)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cigarette or other tobacco use: Amount?\_\_\_\_\_\_\_ Never\_\_\_\_\_\_\_ Quit when\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of drug or alcohol abuse/dependency: Yes\_\_\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_ If yes, please define:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Drug:  | Frequency of use: | Last use: | Impact on your life: | Quantity of use |  |
|  |  |  |  |  |  |
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Drug Rehabilitation: Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*If yes, please describe rehab:

Number and year of Rehabs:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Success:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Failure:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relapse:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of Suicide Attempt(s) or Family member died by Suicide

History of Violence or Use of a Weapon during violent act: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of Seizure(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of Eating Disorder(s):

ACTIVITIES (Political, Community, Social, Sports, Hobbies) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you experienced any stressors (recent or during the past year) that may be contributing to your difficulties?** Yes No

*(eg. illness, deaths, operations, accidents, separations, divorce of parents, parent changes job, child changes school, family moved, family financial problems, remarriage, sexual trauma, other losses)*

**If yes, please describe**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY of ANY SURGERY, HOSPITALIZATION, ACUTE OR CHRONIC ILLNESS**

 **Hospitalization / Surgeries Medical Conditions Requiring Treatment**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Illness / Procedure** | **Date** | **Illness** |
|   |  |  |  |
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**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EDUCATION:**

If you did not complete high school, highest year of school completed:\_\_\_\_Repeated any grades?\_\_\_\_

Types of classes: Regular: \_\_\_\_\_\_Advance: \_\_\_\_\_\_\_\_Extra Assistance \_\_\_\_\_\_\_\_\_

Suspensions (how many and reason):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High School Diploma: Yes\_\_\_When (age or date)\_\_\_\_Obtained GED\_\_\_\_\_\_When (age or date)\_\_\_\_\_\_\_

If you have no academic college degree, number of credits obtained\_\_\_\_\_

List all college degree(s) obtained and when obtained:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vo-Tech Training/ Certifications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHILDHOOD INFORMATION:**

Raised by: Birth parents\_\_\_\_\_\_\_\_\_\_\_\_ and/or Maternal or Paternal Grandparents \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adoptive parents\_\_\_\_\_\_\_\_\_\_\_\_\_ Foster Care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents: Separated: Yes\_\_\_\_ No:\_\_\_\_ \*If parents separated, when (your age or date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where did you grow up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How old were you when you left home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If born outside the USA, when did you first enter the USA\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often did you move during your life and where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Childhood tragedies (loss of home, poverty, war, religious/racial or other discrimination, mental or physical abuse, deaths):

{You prefer not to respond.\_\_\_\_\_\_\_\_\_\_} \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- |
| **PARENTS** | **Age** | **How is your relationship with each?** |
| **Mother** |  |  |
| **Father** |  |  |
| **Stepfather** |  |  |
| **Stepmother** |  |  |

**Frequency of contact with parents:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**BROTHERS and SISTERS (SIBLING) INFORMATION:**

How many siblings do you have?\_\_\_\_\_ You are what number in the birth order?\_\_\_\_\_\_\_\_\_\_\_\_

Please list them by age and parent, if different: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency of contact with siblings:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If any brothers or sisters died, when did this occur and what caused the death?

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

**FAMILY MEDICAL /PSYCHIATRIC HISTORY (parents/ siblings/ aunts/uncle/ grandparents/cousins) (please list any other illness not listed below)**

|  |  |  |
| --- | --- | --- |
|  | **Which Family Member(s)** | **Elaborate** |
| **Thyroid Disease** |  |  |
| **Postpartum Depression** |  |  |
| **Anxiety/ Depression** |  |  |
| **Drug/ Alcohol Abuse** |  |  |
| **Sudden Death**  |  |  |
| **Suicide**  |  |  |
| **Jail**  |  |  |
| **Other**  |  |  |

**MARITAL HISTORY**

If unmarried, please describe pattern of dating history: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If presently married, please offer the following current spousal information:

Spouse’s Age\_\_\_\_\_\_\_\_Spouse’s Health Status\_\_\_\_\_\_\_\_Spouse Disabled?\_\_\_\_\_\_\_\_

Spouse’s Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Marriage(s)** | **Date of Marriage** | **Any Separation(s)?****When/how long/Why?** | **Date of Divorce and cause of divorce?** |
| **First Marriage** |  |  |  |
| **Second Marriage** |  |  |  |
| **Third Marriage** |  |  |  |
| **Fourth Marriage** |  |  |  |

**CHILDREN**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Age of child** | **From Marriage (1st, 2nd, 3rd) Or Extramarital (Extra)** | **Education Level** | **Current & Past History of Each Child****(medical illness/ medication drug & alcohol problems /educational/ work problems / legal problems)** | **Marital status of child****M/S/D/W** | **Are there any grandchildren from any child?** |
|  |  |  |  |  |  |
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**MILITARY HISTORY**

Refused admission into military: Yes\_\_\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_\_\_\_\_

U.S. Military Service? Yes\_\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_Other Nation Military Service?\_\_\_\_\_\_\_\_

How long:\_\_\_\_\_\_\_\_ Which Branch?\_\_\_\_\_\_\_\_ Active Combat? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When Discharged \_\_\_\_\_\_\_\_ Honorable? (if not, please elaborate)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Disciplinary problems in the Service? Yes\_\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_

Disability: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Legal History**

CRIME CONVICTION: Yes\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_DWI: Yes \_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_

Incarceration for any offense: Yes \_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_

Drug related conviction: Yes \_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_ Do you have a driver’s license?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your driver’s license ever been revoked or suspended regardless of reason? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WORK HISTORY**

Are you currently employed? \_\_\_\_\_\_\_\_How many hours do you work a week? \_\_\_\_\_\_\_\_\_\_\_\_\_

If not working, when did you last work?\_\_\_\_\_\_\_\_\_\_

Have you ever been determined permanently totally disabled?\_\_\_\_\_\_\_\_By what agency?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Below list jobs starting with current or last job and work backwards

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Occupation** | **Employer** | **From** | **To** | **Reason For Leaving** |
|  |  |  |  |  |
|  |  |  |  |  |
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*FOR MORE SPACE PLEASE WRITE ON THE BACK OF THIS PAGE*

**Please provide any additional information which you would like me to know or which you feel would be helpful to better understand you**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_