

Behavior Management Systems, Inc.

Confidential Patient Information

Patient Name: _____ Date of Birth: _____

Marital Status: (circle) Married Single Divorced Widowed Separated

Names of Family Members Living in the Home: _____

Medical Information: Are you currently being treated for a medical condition? ____ How long?: _____

Please give specifics: _____

Current Medications and dose (Please include vitamins and across the counter medications.): _____

Have you had significant medical problems in the past? ____ If yes, please explain: _____

(For Women) Number of pregnancies: ____ Problems?: _____

Have you previously been treated for behavioral, psychological, or emotional problems? ____

If yes, please explain: _____

Has anyone in your immediate family been treated for behavioral, psychological, or emotional problems? ____

If yes, please explain: _____

Has anyone close to you had problems with alcohol or drug use? ____ If yes, please explain: _____

Has violence affected your life personally? ____ If yes, please explain: _____

On a **daily basis** In the past month; how much of the following have you used:

Tobacco: _____ Alcohol: _____ Caffeine (cokes, coffee, tea, chocolate): _____

Other stimulants: _____

Have you had a recent change in sleep? ____ If yes, please explain: _____

Have you had a recent change in body weight? ____ If yes, please explain: _____