

Riverwalk Psychotherapy Associates, L.L.C.

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The following are questions asked of all persons beginning service at Riverwalk. The information you provide will assist your therapist in getting to know you as quickly as possible. Please answer all questions as completely as possible. Your answers are confidential and will not be shared with anyone outside the clinic without your written consent.

REFERRED BY: _____ TODAY'S DATE: _____

NAME: _____ BIRTHDATE: _____ AGE: _____

ADDRESS: _____ HOME PHONE: () _____

CITY, STATE _____ ZIP _____ WORK PHONE: () _____

EDUCATION: _____ EMPLOYER: _____ CELL PHONE: () _____

LENGTH OF EMPLOYMENT: _____ POSITION: _____

RELATIONSHIP STATUS:

Single Married(1st) Remarried Separated
 Divorced Widowed Unmarried Couple Domestic Partnership

Length of Relationship: _____ Date of Marriage: _____

PRESENT LIVING SITUATION: Living Alone _____ Or With _____

SPOUSE'S/PARTNER'S NAME: _____ BIRTHDATE: _____ AGE: _____

ADDRESS: _____ HOME PHONE:() _____

CITY, STATE: _____ ZIP: _____ WORK PHONE:() _____

EDUCATION: _____ EMPLOYER: _____ POSITION: _____

LENGTH OF EMPLOYMENT: _____

NEAREST RELATIVE NOT LIVING WITH YOU: _____ PHONE: () _____

OTHERS IN IMMEDIATE FAMILY/HOUSEHOLD (Please include children not living with you):

Name	Relationship	Age	Educ/Occup/Location

(OVER)

FAMILY OF ORIGIN (Parents, Sisters and Brothers):

Name	Age and Health or Date/Cause of Death	Educ/Occup	Living Situation	Location

HEALTH STATUS:

Health/Medical Problems: _____

Current Physical Symptoms: _____

Date of Last Physical Exam: _____ Reason for Exam: _____

Significant Surgery or Hospitalizations: _____

Current Medications (name, amount): _____

Allergies to any Medications: _____

Current Physician (include address): _____

Have you ever experienced the following as a child, teen or adult? (If yes, please list by whom and when).

Physical Abuse: _____

Verbal/Emotional Abuse: _____

Neglect: _____

Intrafamilial Sexual Abuse (Incest): _____

Sexual Assault: _____

Other (describe): _____

Are you currently afraid of anyone in your household? ___yes ___no

If so, Who _____ Why: _____

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10. Do you hear or see things that other people might not?
___Never ___Sometimes ___Occasionally ___Often
11. Do you feel people are trying to harm you or are following you?
___Never ___Sometimes ___Occasionally ___Often
12. Are you bothered by thoughts or actions you cannot control?
___Never ___Sometimes ___Occasionally ___Often
13. Have you ever attempted suicide? ___Yes ___No
14. Have you ever harmed another person causing serious injury or death? ___Yes ___No
15. Do others feel you have a problem with alcohol or other drugs? ___Yes ___No
16. Have you ever lost a friend or had work problems due to alcohol or other drugs?
___Yes ___No
17. Do you feel you have a problem with alcohol or other drugs? ___Yes ___No

Check if you've experienced major changes in the past year:

___Memory ___Concentration ___Appetite ___Sleep
___Job ___Move ___Death in Family
___Relationship ___Other

Please briefly describe the problems that you bring to Riverwalk. Begin with the problem that seems most important for you to work on, and then describe the best and worst outcome you imagine for each problem.

Problem 1: _____

What would be the best outcome for you? _____

What would be the worst outcome for you? _____

Problem 2: _____

What would be the best outcome for you? _____

What would be the worst outcome for you? _____

Is there anything else you feel we should know that would help us in working with you?

