

ADULT LEGAL INTAKE FORM

Referred By: _____ Date: _____

Name: _____ S.S. #: _____

Date of Birth: _____ Driver's License #: _____

Home Address: _____

City:/State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Employer: _____ Occupation: _____

Should contact only be made through your attorney? Yes No

Attorney Name: _____ Phone: _____

Attorney Address: _____

I authorize Wendy E. Coughlin, Ph.D. and my attorney to disclose information to each other about my case.

Client Signature Date

Brief description of legal action with which you are involved:

Dr. Wendy Coughlin, Ph.D.

1101 S. Belcher Rd, Suite E – Largo, FL 33771 ☎ **Phone:** (727) 532-1997

Is this Pre- or Post Court? **Pre** **Post** When is your court date? _____

ADULT LEGAL INTAKE FORM

Have you ever been arrested or convicted of any crimes in the past? If yes, please explain when and what the charges were:

Primary Care Physician: _____ Phone: _____

Address: _____

City / State: _____ Zip: _____

Person Responsible for Payment: _____ Phone: _____

Address: _____

City / State: _____ Zip: _____

Relationship: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Have you ever been in therapy before? Yes No

If Yes, briefly provide details: _____

Have you ever been hospitalized for mental disorders? Yes No

If Yes, briefly provide details: _____

Describe your usual diet, including beverages:

- Breakfast: _____
- Lunch: _____
- Dinner: _____
- Snacks: _____

Dr. Wendy Coughlin, Ph.D.

1101 S. Belcher Rd, Suite E – Largo, FL 33771 ☎ Phone: (727) 532-1997

MEDICAL QUESTIONNAIRE

Name: _____ SS#: _____ Date: _____

What medical problems, if any, are you currently having?

Are those problems being treated? YES NO By whom?

Primary care doctor: _____

Current psychotherapy medication (include dosage and schedule):

Prescribing Physician: _____ PCP Psychiatrist

What prescription or non-prescription drugs (including alcohol) are you currently taking or have taken in the last six months?

List past hospitalizations, operations, or serious illnesses:

- _____ Year: _____
- _____ Year: _____
- _____ Year: _____
- _____ Year: _____

Check any of the following diseases you have had:

Disease	At what age?	Disease	At what age?
<input type="checkbox"/> Thyroid Disorder	_____	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Chronic Bronchitis	_____	<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Emphysema	_____	<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> Epilepsy (convulsion)	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Venereal Disease	_____	<input type="checkbox"/> Anemia	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Kidney Disease	_____
<input type="checkbox"/> Hay Fever	_____	<input type="checkbox"/> Liver Disease	_____
<input type="checkbox"/> Nervous Disorder	_____	<input type="checkbox"/> Hepatitis	_____
<input type="checkbox"/> Other	_____	<input type="checkbox"/> Other	_____

Do you use tobacco? YES NO What form? _____

WOMEN ONLY:

Are you pregnant? YES NO

Dr. Wendy Coughlin, Ph.D.

1101 S. Belcher Rd, Suite E – Largo, FL 33771 ☎ Phone: (727) 532-1997

Perimenopausal? **YES** **NO** Menopausal? **YES** **NO**

MEDICAL QUESTIONNAIRE

Family history with alcohol and/or drugs?

Do you drink alcoholic beverages? **YES** **NO**

How often do you drink? **Daily** **3-5 times per week** **1-2 x per week**
Less

Do you sometimes drink more than you had planned? **YES** **NO**

Have family or friends expressed concern about your drinking before? **YES** **NO**

Have you ever been arrested for alcohol-related charges? **YES** **NO**

Have you ever had an episode where you were unable to remember periods when you are drinking? **YES** **NO**

Have you been treated for addictive illness before? **YES** **NO**

If so, when? _____

Indicate which of the following you use (or have used):	Within 1 year	Used in past
Tranquilizers: Valium <input type="checkbox"/> Xanax <input type="checkbox"/> Ativan <input type="checkbox"/> Klonopin <input type="checkbox"/> Other <input type="checkbox"/>		
Pain Pills: Darvocet <input type="checkbox"/> Oxycontin <input type="checkbox"/> Hydrocodone <input type="checkbox"/> Vicodin <input type="checkbox"/> Percocet <input type="checkbox"/> Morphine <input type="checkbox"/> Heroin <input type="checkbox"/> Methadone <input type="checkbox"/> Other <input type="checkbox"/>		
Stimulants: Amphetamines <input type="checkbox"/> "Speed" <input type="checkbox"/> Dexedrine <input type="checkbox"/> Adderall <input type="checkbox"/> Caffeine <input type="checkbox"/> Other <input type="checkbox"/>		
Sleeping Pills: Lunesta <input type="checkbox"/> Restoril <input type="checkbox"/> Ambien <input type="checkbox"/> Other <input type="checkbox"/>		
"Street Drugs": Marijuana <input type="checkbox"/> Crystal Meth <input type="checkbox"/> "Shrooms" <input type="checkbox"/> Cocaine <input type="checkbox"/> Ecstasy <input type="checkbox"/> Acid <input type="checkbox"/> Crack cocaine <input type="checkbox"/> Other <input type="checkbox"/>		
Volatiles: Aerosols <input type="checkbox"/> Glue <input type="checkbox"/> Whippets <input type="checkbox"/> Other <input type="checkbox"/>		
Others:		

Describe your usual sleep pattern:

Dr. Wendy Coughlin, Ph.D.
 1101 S. Belcher Rd, Suite E – Largo, FL 33771 ☎ **Phone:** (727) 532-1997

Do you snore? YES NO