Resolution Services
Office of Vivian Patton
401 E. Northern Lights Blvd. Suite 205 Anchorage, AK 99503
Phone # (907)770-7769 Fax# (907)770-7634

Name: _____ Birth Date: ____/____/____
Address: _____ Phone: (H) _____
_____ Phone: (C) _____
SSN: _____

Primary Care Physician: _____
Today's Date: ____/____/____
Month and year of last physical: _____

Please check any of the following for which you have received care:

___ allergies	___ headaches	___ heart disease	___ asthma
___ irritable bowel	___ diabetes	___ sleep problems	___ chronic pain
___ epilepsy/seizures	___ emotional problems	___ arthritis	___ hearing problems
___ vision problems	___ stomach problems	___ cancer	___ thyroid problems
___ blood pressure	___ head injury		

Please list any hospitalizations (dates and reasons): _____
Currently under the care of a physician? If so, for what? _____
Please list any prior mental health services received: _____
Please list all medications you are currently taking: _____
_____

Please check any area where you think you have a problem:

___ anxiety, nervousness	___ dental health	___ work/academic
___ behavioral problems	___ depression	___ ADHD
___ parenting	___ sleep	___ stress
___ physical health	___ reproduction	___ anger
___ guilt	___ relationships	___ eating/nutrition
___ weight/body image	___ self-esteem	___ alcohol/other drugs
___ compulsive behavior		

Briefly describe your:
Eating habits: _____
Sleep/rest: _____
Use of alcohol/other drugs: _____
Caffeine intake: _____
Smoking: _____
Physical exercise: _____
Hobbies/play: _____
Please describe any medical concerns not listed above that you believe relevant:
_____
_____
_____
Signature

_____
Date