PATIENT INFORMATION

Date of 1st Appointment: **Today's Date:**

Patient Name: **Gender: Male Female**

Date of Birth: **Place of Birth:**

Age: **Religious Affiliation:**

Home Phone:

Address:

Employer: **Occupation:**

Business Phone: **Cell Phone:**

Education:

Years Completed:

Degrees Obtained:

Marital Status: Single Married Separated Divorced Widowed

Name of Spouse/Significant Other: _____

Date of Birth: _____ Occupation: _____

Education: Years Completed: _____ Degrees Obtained: _____

Date and place of Marriage: _____

Previous Marriages and Children: _____

If divorced, Custodial Parent: _____

Marital Problems? _____

Please list people you feel you can go to for support:

_____

_____

List below all people residing in your home:

Name	Relationship or Status in Home	Birthdate & Age	School Grade or Occupation
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

How were you referred? _____

What events or Circumstances prompted you to call at this time? _____

_____

Describes what you believe has caused the difficulties you are having? _____

_____

_____

What have you done to help these problems? _____

_____

_____

Have you sought professional help before? From whom and for what? Was it helpful? (Examples of professional help might be a social agency such as Family and Children's Service, a hospital, a psychologist, a social worker, a counselor, a psychiatrist.) _____

_____

Family or Personal history of Suicide Attempts? _____

_____

Describe any family difficulties or events which were upsetting (such as: illness or death of a family member or close relative, moves, financial problems, marital stress, sexual or physical abuse). _____

_____

_____

Name: _____Signature: _____

DOB: _____ Information/consent to be completed by the patient

Medical History

Date of most Recent Physical Exam: Results: _____

Please provide the name and address of your physician or medical clinic: _____

Name:

Phone:

Address:

Are you now receiving treatment? _____

List below serious illnesses, accidents, or operations which you have had. Give the date of the illness or injury, and if you were hospitalized, give the name of the hospital, approximate length of stay, and the attending physician.

_____

_____

_____

Medications? (Please list current name dosage and frequency) Please include over the counter and herbal

_____

_____

_____

_____

_____

_____

Allergies?

_____

Preferred Pharmacy: (Please include name, address and phone number)

_____

_____

Family History:

Describe any medical or psychiatric conditions of your parents, siblings and children: _____

_____

_____

_____

Habits: Amount currently using Most ever used

Coffee (cups/day) _____ _____

Cigarettes (packs/day) _____ _____

Alcohol _____ _____

Psychiatric History

Have you ever received psychiatric or psychological treatment of any kind before? Yes No

If you checked yes to the above question please answer the following:

What type of care did you receive? Inpatient (hospital) Outpatient Both

Where were you in treatment?

_____

_____

When were you in treatment? _____

How long were you in treatment? _____

Who was your therapist or doctor? _____

Did your doctor prescribe Medicine at that time? Yes No Not applicable

If yes what was prescribed (include dosage if know)? _____

_____

_____

_____

Substance Use History

Have you ever abused drugs or alcohol? Yes No If yes, please describe:

Substances	Amount	Frequency	When? (First use; Last use)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Name: _____Signature: _____

DOB: _____ Information/consent to be completed by the patient

Symptoms and Behaviors

____ physical problems

____ recurring thoughts

____sexual abuse history

____shyness around people

____ alcohol use

____ anxiety

____ athletic or work performance

____ concentration problems

____ depression

____ eating issues

____ elevated mood

____ fatigue

____ sexual performance

____ other (please list) _____

____ sexual assault/rape

____ relationship problems

____ sexual identity/orientation

____ aggression

____ anger

____ avoiding people

____ career/academic difficulties

____ coping with prejudice

____ drug use

____ racial/ethnic identity

____ family problems

____ friendship problems

____ pornography addiction

Please rank order the top 5 symptoms checked above by priority and severity:

(#1 = most pressing concern, #2 = moderately pressing concern, etc)

1) _____
2) _____
3) _____
4) _____
5) _____

Name: _____Signature: _____

DOB: _____ Information/consent to be completed by the patient

On average how many hours of sleep do you get daily? _____

Do you have problems sleeping? ____Yes ____No (if yes, please describe):

_____
_____
_____

Are you on any specific diet (ex: lactose free, gluten free, high protein, etc)? ___ Yes ___ No

If yes, please describe:

_____
_____

Have you gained/lost over 10 pounds in the past year? ___Yes ___No (___gained ___lost)

If yes, was the gain/loss on purpose? ___Yes ___No

If known, how did the weight change occur?

_____
_____

Describe your appetite (during the past 2-3 weeks):

____ poor appetite ____ average appetite ____ large appetite

Describe your energy level (during the past 2-3 weeks):
____ low energy ____ moderate energy ____ high energy

Name: _____Signature: _____

DOB: _____ Information/consent to be completed by the patient

About You

What do you like to do for fun?

_____

What is your favorite book?

_____

What is your favorite type of music? Do you have a favorite musician or band?

_____

What is your personal philosophy?

_____
_____
_____

What are you hoping I can help you with?

_____
_____
_____

What would be different if the above issue was fixed? How would your life be different?

_____
_____
_____

Who inspires you? Why?

_____
_____
_____

What or who has taught you the most about life?

_____
_____
_____

What are some of your goals for this year?

_____
_____
_____

What are some of your long-term goals?

_____
_____
_____