

PATIENT INFORMATION

Date of 1st Appointment:

Today's Date:

Patient Name:

Gender:

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:

Current use:

Most used:

Coffee (cups/day) _____

Cigarettes (packs/day) / Vaping _____

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

- | | |
|---|---|
| <input type="checkbox"/> physical problems | <input type="checkbox"/> sexual assault/rape |
| <input type="checkbox"/> recurring thoughts | <input type="checkbox"/> relationship problems |
| <input type="checkbox"/> sexual abuse history | <input type="checkbox"/> sexual identity/orientation |
| <input type="checkbox"/> shyness around people | <input type="checkbox"/> aggression |
| <input type="checkbox"/> alcohol use | <input type="checkbox"/> anger |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> avoiding people |
| <input type="checkbox"/> athletic or work performance | <input type="checkbox"/> career/academic difficulties |
| <input type="checkbox"/> concentration problems | <input type="checkbox"/> coping with prejudice |
| <input type="checkbox"/> depression | <input type="checkbox"/> drug use |
| <input type="checkbox"/> eating issues | <input type="checkbox"/> racial/ethnic identity |
| <input type="checkbox"/> elevated mood | <input type="checkbox"/> family problems |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> friendship problems |
| <input type="checkbox"/> sexual performance | <input type="checkbox"/> pornography addiction |
| <input type="checkbox"/> other (please list) _____ | |

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?
