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Patient Information Form

Name_____ 1st Appt. Date_____ Date of Birth_____

Street Address _____ City _____ State _____ Zip Code_____

Phone Number _____ Age _____ Gender (Circle One): Male - Female

Social Security No. _____

Medical History

Name of Primary Care Physician: _____

Physician's Address:_____

Physician's Phone: _____

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above-named doctor? (Circle One) YES - NO

Please sign here for either answer: _____

Date of last medical evaluation: _____ Date of next appointment: _____

Current medications being taken:

Medication	*Dosage/Freq*	*Start Date*	*Purpose*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Prescribed by: _____

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES - NO

Hospital	*Mo/Yr*	*Reason*
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you use recreational drugs? (Circle One) YES - NO If no, have you used previously? (Circle One) YES - NO

If yes, when did you stop? _____

Type of Drug	*How much*	*How often*
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you drink alcohol? (Circle One) YES - NO If no, did you drink previously? (Circle One) YES - NO

If yes, please list:

Type of Alcohol	*How much*	*How often*
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you smoke cigarettes? (Circle One) YES - NO Do you use other forms of tobacco? (Circle One) YES - NO

If yes, what kind? _____

Describe any important medical history, chronic ailments, or other health problems you experience: _____

_____

_____

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments: _____

_____

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list: _____

_____

School & Family History

Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers? (Circle One) YES - NO If yes, please explain: _____

_____

What was the last year of school you completed? _____ If you did not complete high school, please explain: _____

_____

Please list schools: *(1) currently attending* *(2) last attended* *(3) graduated:*

(1) School(s)_____ Year(s)_____

(2) School(s)_____ Year(s)_____

(3) School(s)_____ Year(s)_____

How would you describe your current support network? (friends, relatives, etc.): _____
_____

Please check all information which applies to your biological parents:

MOTHER	____ living	FATHER	____ living
	____ deceased		____ deceased
	____ married		____ married
	____ divorced		____ divorced
	____ remarried ____# of times		____ remarried ____# of times

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? If so, whom?

_____

Where do your parents live? Mother _____

Father _____

Describe your relationship with your mother while growing up: _____

_____

Currently: _____

_____

Describe your relationship with your father while growing up: _____

_____

Currently: _____

_____

List first names and ages of brothers & sisters, including yourself:

Name	*Age*	*Relationship (natural, step, half, etc.)*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any family problems which occurred while growing up relating to alcohol/drug abuse: _____

_____

Describe any family problems which occurred while growing up relating to sexual/physical/emotional abuse: _____

_____

_____

Marital History

Marital status (Circle One): Single/Never Married - Married - Separated - Divorced - Widowed - Living w/Someone

If currently married, when were you married? _____ If living w/someone, how long? _____

Please list your children:

Name	*Age*	*Relationship (biological/step)*	*Lives with*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Mental Status

Please circle any of the following that describe how you have been feeling lately:

sad anxious depressed frightened guilty angry ashamed aggressive

resentful worthless tearful irritable confused extreme ups/downs jealous

hopeless helpless overwhelmed

Describe any other feelings you have had: _____

_____

What activities or hobbies do you participate in? _____

_____

Do you participate in regular exercise? (Circle One) YES - NO Describe: _____

_____

Describe your current working environment: _____

_____

Have you had any change in sleeping habits? (Circle One) YES - NO Describe: _____

_____

Have you had any change in eating habits? (Circle One) YES - NO Describe: _____

_____

Have you ever **considered suicide** in connection to your **current** problem? (Circle One) YES - NO

If so, please give a brief description with dates: _____

_____

Have you ever **considered suicide** in the **past**? (Circle One) YES - NO

If so, please give a brief description with dates: _____

_____

Have you **attempted suicide recently** or in the **past**? (Circle One) YES - NO

If so, please give a brief description with dates: _____

_____

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? (Circle One) YES - NO

If yes, please explain: _____

_____

Have you ever **considered homicide** in the **past**? (Circle One) YES - NO

If yes, please explain: _____
_____

Level of Functioning

List or describe any current impediments or problems in daily psychological, social or occupational functioning (i.e. isolation from friends/family, significant difficulty getting to work or completing daily tasks, severe financial strain, recent divorce, and problems with supervisor, etc.): _____

_____

THOUGHTS: Please check any of the following that apply to you:

_____I sometimes hear voices even though no one nearby is talking to me.
_____I sometimes feel that forces outside of me control me.
_____I sometimes feel that other people control my thoughts.
_____I sometimes have the same thought over and over and cannot control it.
_____I sometimes feel that someone is out to hurt me or do something against me.
_____I am sometimes unable to control my behavior.

Please explain: _____

_____

_____

_____

_____

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.

_____

_____

_____

_____

_____

Please list your therapy goals:

_____

_____

_____

_____

_____

THANK YOU!