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PATIENT INFORMATION FORM/CONFIDENTIAL INFORMATION

This form will save both you and your practitioner time, providing you with the best service possible. All information provided on this form is considered confidential. Please answer as carefully and completely as possible.

Today's Date__________________________

Name __________________________________Date of Birth ______________________Age__________________

Marital Status ( ) Never Married ( ) Married ( ) Living as Married
( ) Separated ( ) Divorced ( ) Widowed

Partner's Occupation ____ Partner's age__________________________

Race/Culture____

Do you have any children? ( ) No ( ) Yes If yes, give names, ages and where they live:

Name	Sex Age	Whereabouts
________________________	_______	____
________________________	_______	____
________________________	_______	____

Anyone else living in the household? ( ) No ( ) Yes If yes, who? ____

You were referred by ______________________Relationship to you____

Who is your primary care physician? ____

Previous therapy or counseling? (Please list names of clinicians and approximate dates of therapy)

____

____

____

Previous psychiatric medications. (Please approximate when used, how long and why medication was discontinued or changed)

____

____

____

Current psychiatric medication

____

____

____

Issues that bring you into therapy at this time

____

____

____

FAMILY HISTORY

Frequently it is helpful for the clinician to have a sense of your family of origin issues as they allow us to gather a more complete picture of your psychological functioning. Please take a moment to complete this section.

Father: Age_______ ( ) Living ( ) Deceased If deceased, **YOUR** age at time of death _______
Occupation: ____
Health: ____
Frequency and kind of contact with him: ____

Mother: Age_______ ( ) Living ( ) Deceased If deceased, **YOUR** age at time of death _______
Occupation: ____
Health: ____
Frequency and kind of contact with her: ____

Brothers and/or Sisters:

Full Name Sex Age Whereabouts
____
____
____
____

Please place a check mark in the appropriate box if these are or have been present in your relatives.

	Children	Brother	Sister	Mother	Father	Uncles/Aunt	Grandparents
Nervous Problems							
Depression							
Drinking Problem							
Drug Problem							
Psychiatric Treatment							
Attention Deficit							
Hyperactivity							
Epilepsy							
Suicide							
Mental Illness							
Mental Retardation							
Learning Disorder							

EDUCATIONAL HISTORY

Did you have any difficulties in school please describe them______________________
____
____

Were you considered hyperactive/ADHD in school? ( ) No ( ) Yes If yes, did you take medication? ( ) No ( ) Yes If yes, list medication and dosage:

____

____

History of problems with learning? ____

What kind of grades did you get in school? ____

Please list the higher degree you completed in school. ____

SUBSTANCE USE HISTORY

Have you ever had a history of substance use or abuse with prescription pain medication? (e.g., Percodan, Percocet, Tylenol with Codeine, Demerol, Darvocet, Vicodin)

____

____

____

Ever used for GREATER THAN ONE MONTH? ( ) No ( ) Yes If yes, please list:

Type _______________________Age of 1st use _____Time since last use ____________________________________
Approximate use in past 30 days____

Type _______________________Age of 1st use _____Time since last use ____________________________________
Approximate use in past 30 days____

Have you ever had a history of substance use or abuse with anti-anxiety agents (e.g., Valium, Ativan, Xanax, K1onopin, Librium)

____

____

____

Ever used for GREATER THAN ONE MONTH? ( ) No ( ) Yes If yes, please list:

Type _______________________Age of 1st use _____Time since last use ____________________________________
Approximate use in past 30 days____

Type _______________________Age of 1st use _____Time since last use ____________________________________
Approximate use in past 30 days____

ALCOHOL USE HISTORY

Do you drink alcohol? ( ) No ( ) Yes If yes, age of first use ____

How frequently do you drink? **(Please circle one)**: daily twice a week weekly monthly or less

How much alcohol do you consume when you drink? ____

Have you ever had a Black out when drinking? ( ) No ( ) Yes if yes, how often? ____________________________

Have you ever had a seizure due to your alcohol use? ( ) No ( ) Yes If yes, how often? __________________________

Please indicate below whether you ever have used any other substances:

"Street "Drugs (e.g., Marijuana, Heroin, Methamphetamine, Cocaine, Crank, PCP, Uppers, Downers,

Magic Mushrooms, "Sniffing/Huffing" Paint, LSD, Ecstasy): Other: ___________________________________

____

Ever Used? ( ) No ( ) Yes   If yes, please list below:

Type _______________________Age of 1st use _____Time since last use ____________________________________
Approximate use in past 30 days____

Type _______________________Age of 1st use _____Time since last use ____________________________________
Approximate use in past 30 days____

Type _______________________Age of 1st use _____Time since last use ____________________________________
Approximate use in past 30 days____

C.A.G.E.

1. Have you ever felt you should cut down on your drinking/drug use? ( ) No ( ) Yes
2. Have people annoyed you by criticizing your drinking/drug use? ( ) No ( ) Yes
3. Have you ever felt bad or guilty about your drinking/drug use? ( ) No ( ) Yes
4. Have you ever drank/used drugs in the morning to steady your nerves or to relive a hangover (eye opener)? ( ) No ( ) Yes

Do you use tobacco? ( ) No ( ) Yes If yes, describe? ____

Do you drink caffeinated beverages (coffee, tea, cola)? ( ) No ( ) Yes If yes, describe type and amount?

____

____

OCCUPATIONAL HISTORY

Have you ever served in the military? ( ) No ( ) Yes If yes, describe? ____

What type of discharge did you get? ____

____

Current Employment Status:

____

Please give a brief list of your job history:

Type of Job	Date	Reason for Leaving
____________________________	____________________	____
____________________________	____________________	____
____________________________	____________________	____

PSYCHOSOCIAL HISTORY

Have you ever been arrested? ( ) No ( ) Yes If yes, describe:

Year ________ Reason for arrest_____________________________ Disposition________________________________

Year ________ Reason for arrest_____________________________ Disposition________________________________

Do you have a religious affiliation? ( ) No ( ) Yes If yes, describe ____

What kind of social activities hobbies do you participate in? ____
____
____
____

Who do you turn to for support or help with your problems? ____

____

Have you ever been abused? ( ) verbally ( ) emotionally ( ) physically ( ) sexually ( ) neglected

( ) No ( ) Yes If yes, please describe____
____

MEDICAL STORY

Any prior major illnesses, operations, and/or accidents (please provide dates)
____
____
____

Do you suffer from sleep problems (too much/too little)? ____
____

Do you feel rested when you wake up? ( ) No ( ) Yes

Do you suffer from Allergies? ( ) No ( ) Yes If yes, list the allergens: _______________________________________

______________________________________If yes, what medications are used for treatment? ___________________
____

Indicate CURRENT medical conditions. Check the appropriate box and if YES, specify condition (s)

	Yes	No	
1. Ear, nose, and throat	( )	( )	____________________
2. Eyes	( )	( )	____________________
3. Respiratory	( )	( )	____________________
4. Cardiovascular	( )	( )	____________________
5. Gastrointestinal	( )	( )	____________________
6. Pancreas	( )	( )	____________________
Liver	( )	( )	____________________
7. Urinary system	( )	( )	____________________
8. Reproductive system	( )	( )	____________________
Birth control method	( )	( )	____________________
9. Neurology	( )	( )	____________________
Tics	( )	( )	____________________
Movement problems	( )	( )	____________________
Tremors, shakes, jitters	( )	( )	____________________
Strokes	( )	( )	____________________
10. Blood & lymphatic	( )	( )	____________________
11. Endocrine & metabolic	( )	( )	____________________
12. Musculoskeletal	( )	( )	____________________

13. Skin ( ) ( ) ____
14. Head Injury ( ) ( ) ____
15. Loss of consciousness ( ) ( ) ____
16. Recurrent headaches ( ) ( ) ____
17. Migraines ( ) ( ) ____
18. Asthma ( ) ( ) ____
19. Diabetes ( ) ( ) ____
20. Seizure Disorder ( ) ( ) ____
21. Sexually Transmitted Diseases ( ) ( ) ____
HIV/ AIDS ( ) ( ) ____
22. Hepatitis ( ) ( ) ____
23.0ther ( ) ( ) ____

When was your last complete physical exam? ____
Who performed the physical? ____
Did you have blood work done? ( ) No ( ) Yes If yes, what were the results__________________________

LIFE EXPERIENCE CHECKLIST

The following lists refer to your present level of experience. Please place an X in the column next to the items that best describe how you currently feel. Then, describe how long you have felt that way (e.g., days, weeks months, years).

I am experiencing… **For how long (days, weeks, months, years)**

( ) Feelings of tiredness ____
( ) Feelings of anger ____
( ) Outbursts of anger ____
( ) Feeling numb ____
( ) Feeling down____
( ) Feelings of guilt____
( ) Feelings of anxiety ____
( ) A desire to be socially isolated ____
( ) Frustration ____
( ) Irritability____
( ) Pain symptoms____

Persistent feelings of:
( ) Worthlessness____
( ) Helplessness____
( ) Hopelessness ____
( ) Fear____

Persistent loss of interest in previously enjoyed activities:
( ) Withdrawing from other people____
( ) Spending increased time alone ____
( ) Problems with friends____

Avoidance of:
( ) People ____
( ) Places____
( ) Activities or specific things____________________________________
( ) Leaving your home____

Repetitive behaviors or mental acts:

( ) Counting ( ) Checking doors ( ) Washing hands____

Fear of certain objects or situations: ( ) Crowds ( ) Traffic ( ) Being alone ( ) Dark ______________________________
( ) Strangers ( ) Animals

( ) Difficulty catching breath
( ) Increased energy
( ) Startle easily, feeling "jumpy"
( ) Tremor
( ) Dizziness
( ) Increase in appetite
Wt. Gain_____lbs Over what period of time____
( ) Decrease in appetite
Wt. Loss_____lbs Over what period of time____
( ) Purging ____
( ) Voluntary vomiting ____
( ) Use of laxatives ____
( ) Excessive exercise (avoids weight gain) ____
( ) Binge eating ____
( ) Overeating ____

Difficulty with sleep:
( ) Falling asleep ____
( ) Staying asleep ____
( ) Getting out of bed ____

( ) Physical sensations others don't have ____
( ) Racing thoughts ____
( ) Difficulty concentrating or thinking ____
( ) Difficulty making decisions ____
( ) Persistent thought about harming or killing yourself ____
Have you ever attempted suicide? ( ) Yes ( ) No
( ) Persistent thoughts about harming or killing someone else____
Have you ever acted on your thoughts? ( ) Yes ( ) No
( ) Frequent worry____
( ) Intrusive memories (flashback, nightmares) ____
( ) Large gaps in your memory ____
( ) Occupational problems____
( ) Sexual dysfunction ____
Problems with desire ____
Problems with arousal ____
Problems with organism ____
( ) Difficulty starting tasks ____
( ) Difficulty finishing tasks ____
( ) Feeling as if you were outside yourself, detached, observing what you are doing____________________________
( ) Feeling puzzled as to what is real and unreal ____
( ) Persistent, repetitive, intrusive thoughts, impulses or images ____
( ) Unusual visual experience such as flashes of light, shadows ____
( ) Hear voice(s) when no one else is present ____
( ) Feeling that your thoughts are controlled or placed in your mind _______________________________________
( ) Feeling that the television or the radio is communicating with you ______________________________________
( ) Difficulty problem solving ____
( ) Difficulty meeting role expectations ____
( ) Dependency on others ____
( ) Manipulation of other to fulfill own desires ____
( ) Inappropriate expressions of anger____
( ) Self-mutilation____
Cutting ____
Burning ____
Jumping ____
Hitting ____
( ) Difficulty or inability to say "no" to others ____
( ) Problems with communication ____
( ) Sense of lack of control ____

( ) Decreased ability to handle stress ____
( ) Abusive relationship ____
( ) Difficulty expressing emotion ____
( ) Often experience physical problems in place of feeling emotional problems ______________________________
( ) Concerns about sexuality____
Hypersexuality ____
Sexually risk taking behavior____
Gender Orientation ____
Other____

Sexual Orientation ( ) heterosexual ( ) homosexual ( ) bisexual

I think....
( ) My life is out of control ____
( ) I have hallucinations ____
( ) Alcohol or drugs affect my life ____
( ) Life is without opportunities____
( ) I am without hope ____
( ) I am unable to understand the things I do ____
( ) I have blackouts ____
( ) I am unable to change my circumstances____
( ) I abuse prescribed medication____

Please describe any other symptoms or experience you have had problems with:
____
____
____
____
____

If you had 3 wishes what would they be?

1.____

2.____

3.____