Oyster Bay Mental Health Counseling PLLC
1035 Oyster Bay Road, Suite C
East Norwich, NY 11732
516.802.5676

Social History

Client Information

Full Name: _____ DOB: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Cell Phone: _____ Email: _____

Today's Date: _____ Education.: _____ Profession: _____

Employer's Name: _____

Employer's Phone No: _____

Emergency Contact

Full Name: _____ Relation: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Cell Phone: _____ Email: _____

Employer's Name: _____

Employer's Phone No: _____

Insurance Information

Insured Person: _____ Relation to Client: _____

Insurance Company: _____ **Policy No.:** _____

Address: _____

Phone No.: _____

SSN (last 4 digits).: _____ DOB: _____

Personal History

Medical Information

Full Name: _____ Gender: _____

Current Concerns: _____

_____

Primary Physician: _____ Phone No.: _____

Psychiatrist: _____ Phone No.: _____

Prior Medical Conditions: _____

Current Medications: _____

Drug or Alcohol Use (Frequency): _____

Client Questionnaire

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Please Circle One

1. Little interest or pleasure in doing things

0 - Not at all	1 - several days	2 - More than half the days	3 - Nearly Every Day

2. Feeling down, depressed or hopeless

0 - Not at all	1 - several days	2 - More than half the days	3 - Nearly Every Day

3. Trouble falling asleep, staying asleep, or sleeping too much

0 - Not at all	1 - several days	2 - More than half the days	3 - Nearly Every Day

4. Feeling tired or having little energy

0 - Not at all	1 - several days	2 - More than half the days	3 - Nearly Every Day

5. Poor appetite or overeating

0 - Not at all	1 - several days	2 - More than half the days	3 - Nearly Every Day

6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down

0 - Not at all	1 - several days	2 - More than half the days	3 - Nearly Every Day

7. Trouble concentrating on things, such as reading the newspaper or watching television

0 - Not at all	1 - several days	2 - More than half the days	3 - Nearly Every Day

8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual

0 - Not at all	1 - several days	2 - More than half the days	3 - Nearly Every Day

9. Thoughts that you would be better off dead or of hurting yourself in some way

0 - Not at all	1 - several days	2 - More than half the days	3 - Nearly Every Day

10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult at all	Somewhat Difficult	Very Difficult	Extremely Difficult

Family History

Marital Status: _____

Relationship with Mother _____

Relationship with Father _____

Relationship with Siblings: _____

Where did you grow up? _____

Who did you live with? _____

At what age did you leave home? _____

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

Signature: _____ Date: _____

Referred by

Person:	
Advertisement:	
Website:	
Other:	