Ψ Clinical Psychology

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Demographic Information

Today's date: _____

A. Identification

Your name: _____Date of birth: _____ Age: _____
Your nicknames or aliases: _____ Social Security #: _____
Home street address: _____ Apt.:_____
City: _____ State: _____Zip: _____
Home/evening phone: _____ Calls will be discreet, but please indicate any restrictions:_____
_____

B. Referral: Who gave you my name to call?

Name: _____ Phone: _____
Address: _____
_____
May I have your permission to thank this person for the referral? Yes No
How did this person explain how I might be of help to you? _____
_____
_____

C. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____
Address: _____
If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? Yes No

D. Your current employer

Employer: _____ Address: _____
_____
Work phone: _____Calls will be discreet, but please indicate any restrictions: _____
_____

E. Your education and training

Dates From	To	Schools	Special Classes?	Adjustment to school	Did you graduate?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

F. Employment and military experiences

Dates From	Dates To	Name of military or employers	Job title or duties	Reason for leaving

G. Family-of-origin history

Relative	Name	Current age (or deceased)	Illness (or cause of death, if deceased)	Education	Occupation
Father					
Mother					
Stepparents					
Grandparents					
Uncles/aunts					
Brothers					
Sisters					

H. Marital/relationship history

Spouse's name	Spouse's age at marriage	Your age at marriage	Your age when divorced/widowed	Is spouse remarried?
First				
Second				
Third				

I. Significant nonmarital relationships

	Name of person	Person's age when started	Your age when started	Your age when ended	Reasons for ending
First					
Second					
Third					

J. Children (Indicate which are from a previous marriage or relationship with the letter P in the last column)

Name	Current age	Sex	School	Grade	Adjustment problems?	P?

Clinical Information

A. Chief concern

Please describe the main difficulty that has brought you to see me: _____

B. Treatment

1.Have you ever received psychological or psychiatric or counseling services before? No Yes If yes, please indicate:

When?	From whom?	For what?	With what results?

2.Have you ever taken medications for psychiatric or emotional problems? No Yes If yes, please indicate:

When?	From whom?	Which medications	For what	With what results?

C. Relationships in your family of origin. Please describe the following:

1. Your parents' relationship with each other: _____

2. Your relationship with each parent and with other adults present: _____

3. Your parents' physical health problems, chemical use, and mental or emotional difficulties: _____

4. Your relationship with your brothers and sisters, in the past and present: _____

D. Abuse history: I was not abused in any way. I was abused. If you were abused, please indicate the following. For kind of abuse, use these letters: P = Physical, such as beatings. S = Sexual, such as touching/molesting, fondling, or intercourse. N = Neglect, such as failure to feed, shelter, or protect you. E = Emotional, such as humiliation, etc.

Your age	Kind of abuse	By whom?	Effects on you?	Whom did you tell?	Consequences of telling?

E. Present relationships

1. How do you get along with your present spouse or partner? _____
_____
_____
_____

2. How do you get along with your children? _____
_____
_____
_____

3. Your important friends, past and present:

Names	Good parts of relationship	Bad parts of relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

F. Chemical use

1. Have you ever felt the need to cut down on your drinking? No Yes
2. Have you ever felt annoyed by criticism of your drinking? No Yes
3. Have you ever felt guilty about your drinking? No Yes
4. Have you ever taken a morning "eye-opener"? No Yes
5. How much beer, wine, or hard liquor do you consume each week, on the average?_____
_____
6. How much tobacco do you smoke or chew each week? _____
7. Which drugs (not medications prescribed for you) have you used in the last 10 years? _____
_____
_____

Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects, and so forth: _____
_____
_____

G. Legal history

1. Are you involved in any current or pending civil or criminal litigation, lawsuit or divorce or custody dispute? No Yes If yes, please explain:
_____
_____

2. Are there any other legal involvements I should know about? _____
_____
_____

Health Information

A. History

1. Starting with your childhood and proceeding up to the present, list *all* diseases, illnesses, important

accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had. (Describe pregnancies in section E.)

Age	Illness/diagnosis	Treatment received	Treated by	Result

2. Describe any allergies you have.

To what?	Reaction you have	Allergy medications you take

3. List *all* medications or drugs you take or have taken in the last year—prescribed, over-the-counter, and others.

Medication/drug	Dose (how much?)	Taken for	Prescribed and supervised by

4. Have you done any kinds of work where you were exposed to toxic chemicals?

Date	Kinds of chemicals	Kind of work	Effects

B. Medical caregivers

1. Your current family or personal physician or medical agency:

Name	Specialty	Address	Phone #	Date of last visit

2. Other physicians treating you at present or in last 5 years:

Name	Specialty	Address	Phone #	Date of last visit

C. Health habits

1. What kinds of physical exercise do you get? _____
_____
_____
2. How much coffee, cola, tea, or other sources of caffeine do you consume each day? _____
_____
_____
3. Do you try to restrict your eating in any way? How? Why? _____
_____
_____
4. Do you have any problems getting enough sleep? _____
_____
_____

D. For women only

1. At what age did you start to menstruate (get your period):_____

2. Menstrual period experiences:
   a. How regular are they? _____
   b. Problems or symptoms with period? _____

3. Please list all of your pregnancies:

		What happened with this pregnancy?			
	Your age	Miscarriage	Abortion	Child born	Problems?
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____

4. Menopause:
   a. If your menopause has started, at what age did it start? _____
   b. What signs or symptoms have you had? _____
   _____

E. Other medical

Are there any other medical or physical problems you are concerned about? _____
_____
_____
_____
_____

Any other concerns

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper:

_____
_____
_____
_____