GODMAN PSYCHOLOGICAL SERVICES, P.C.
Helping to navigate the mind
4231 Balboa Avenue #1256
San Diego, CA 92117
T: (619) 785-6995
info@godmanpsych.com

Mental Health Patient Information Form

I. Personal Information

- Full Name: _____
- Date of Birth: _____ Age: _____
- Gender: ☐ Male ☐ Female ☐ Non-binary ☐ Other: _____
- Preferred Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other: _____
- Address: _____
- Phone Number: _____ Email: _____
- Emergency Contact Name: _____ Relationship: _____
- Emergency Contact Phone Number: _____

II. Medical and Psychiatric History

- Primary Care Physician: _____ Phone: _____
- Are you currently receiving psychiatric treatment? ☐ Yes ☐ No
    - If yes, name of provider: _____
- Have you previously been in therapy? ☐ Yes ☐ No
    - If yes, when and for how long? _____
- Current Medications (including psychiatric and non-psychiatric):
    - Medication: _____ Dosage: _____ Prescribing Doctor: _____
    - Medication: _____ Dosage: _____ Prescribing Doctor: _____
    - Medication: _____ Dosage: _____ Prescribing Doctor: _____

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- Any known medical conditions (e.g., diabetes, heart disease, chronic pain)? _____
- Any history of hospitalization for mental health reasons? ☐ Yes ☐ No
    - If yes, please provide details (dates, reasons, location): _____
- Any history of substance use or addiction? ☐ Yes ☐ No
    - If yes, please specify substances used and treatment history: _____

III. Family and Social History

- Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____
- Children? ☐ Yes ☐ No If yes, number and ages: _____
- Do you have a family history of mental illness? ☐ Yes ☐ No
    - If yes, please specify (e.g., depression, schizophrenia, bipolar disorder, etc.): _____
- Any history of suicide or suicide attempts in the family? ☐ Yes ☐ No
    - If yes, please explain: _____
- Current Employment/School Status: ☐ Employed ☐ Unemployed ☐ Student ☐ Retired
    - If employed, occupation: _____ Employer: _____
    - If student, school name: _____ Major (if applicable): _____
- Do you have a support system (e.g., family, friends, religious groups)? ☐ Yes ☐ No
    - If yes, please describe: _____

IV. Mental Health and Suicide Risk Assessment

- Have you ever had thoughts of harming yourself? ☐ Yes ☐ No
    - If yes, how frequently? ☐ Rarely ☐ Occasionally ☐ Frequently
- Have you ever attempted suicide? ☐ Yes ☐ No

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- If yes, when and what method? _____

- Do you currently have thoughts of self-harm or suicide? ☐ Yes ☐ No
  - If yes, do you have a plan? ☐ Yes ☐ No If yes, please describe: _____
- Have you ever engaged in self-harming behaviors (e.g., cutting, burning)? ☐ Yes ☐ No
- Have you recently experienced significant stress, loss, or trauma? ☐ Yes ☐ No
  - If yes, please describe: _____
- Do you have access to means of self-harm (e.g., firearms, medication)? ☐ Yes ☐ No
- Have you ever had thoughts of harming others? ☐ Yes ☐ No
  - If yes, please describe: _____
- Are you currently experiencing any of the following? (Check all that apply)
  - ☐ Persistent sadness or depression
  - ☐ Anxiety or excessive worry
  - ☐ Mood swings
  - ☐ Difficulty sleeping
  - ☐ Difficulty concentrating
  - ☐ Panic attacks
  - ☐ Hallucinations or delusions
  - ☐ Substance cravings or withdrawal symptoms
  - ☐ Increased anger or irritability
- On a scale of 1 to 10, how would you rate your current mental health? (1 = Very Poor, 10 = Excellent) ____

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V. Additional Information

- What are your goals for therapy? _____
- Is there anything else you would like your therapist to know? _____

Signature & Consent By signing below, I affirm that the information provided is accurate to the best of my knowledge. I consent to participate in a mental health evaluation and/or treatment.

Client Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____