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INDIVIDUAL AND CHILD PSYCHOTHERAPY

Patient Information Form

Today's date: _____

Note: If you have been a patient here before, please fill in only the information that has changed.

A. Identification

Patient's name: _____ Date of birth: _____ Age: ____

Name of Parent/Guardian (if patient is minor): _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Billing Address (if different from above): _____

Home/evening phone: _____ Cell phone: _____

Email: _____Is it ok to e-mail? (yes / no) Is it ok to text? (yes / no)

Is it ok to leave message on your home phone (yes / no) on your cell phone (yes / no)

Calls or e-mail will be discreet, but please indicate any restrictions: _____

Hours Available: _____

Combined Income: (only answer if requesting sliding scale): _____

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. Religious and racial/ethnic identification

Current religious denomination/affiliation ❑ Protestant ❑ Catholic ❑ Jewish ❑ Islamic ❑ Buddhist ❑ Hindu

Other (specify): _____

Involvement: ❑ None ❑ Some/irregular ❑ Active

How important are spiritual concerns in your life? _____

Which (if any) church, synagogue, temple, or meeting are you involved with? _____

Ethnicity/national origin: _____ Race: _____ or other similar way you identify yourself and consider important: _____

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

Clinic/doctor's name: _____ Phone: _____

Address: _____

Do you have or have you had any major illnesses, injuries or chronic problems that have required attention of the years? Yes: _____ No: _____ If yes, please describe (include hospitalizations):

_____

Are you taking any medications? Yes: _____ No: _____ If yes, please list the medications, who is prescribing them, and for what conditions: _____

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

E. Psychiatric Contact (Name):_____Phone:_____

Why are you coming to therapy at this time? _____

_____

How do you think the problem developed? _____

_____

What do you want to accomplish in therapy? _____

_____

How long do you think your therapy should last? _____

What hours are you available for appointments: AM_____ PM_____ Time:_____

Have you ever seen anyone for help with your problems before? Yes:_____ No:_____

Name of Agency/Therapist: _____

When: _____ How Long: _____

Why did you see this person? _____

Have you ever been hospitalized for psychiatric and/or substance abuse? Yes: _____ No:_____

Name of Hospital:_____

When: _____ For what problem: _____

Legal Problems:_____ Financial Status:_____

The following information will help me to know and understand more about your needs. We will then work together to develop a plan for your therapy that addresses your needs. Please review the following questions and choose the number that best represents your sense of your **RECENT** functioning.

RECENTLY how are you functioning at school/work/home?

1	2	3	4	5	6	7	8	9	10
Very Poorly									Very Well

RECENTLY how are you functioning in intimate/partner/love relationships?

1	2	3	4	5	6	7	8	9	10
Very Poorly									Very Well

RECENTLY how are you functioning in family and child-rearing relationships?

1	2	3	4	5	6	7	8	9	10
Very Poorly									Very Well

RECENTLY how are you functioning in other social situations, with friends, at public gatherings, etc.?

1	2	3	4	5	6	7	8	9	10
Very Poorly									Very Well

RECENTLY how are you functioning in day-to-day tasks of living, including taking care of finances and legal matters?

1	2	3	4	5	6	7	8	9	10
Very Poorly									Very Well

RECENTLY how are you functioning in taking good care of yourself physically and emotionally?

1	2	3	4	5	6	7	8	9	10
Very Poorly									Very Well

RECENTLY how are you functioning in spiritual areas?

1	2	3	4	5	6	7	8	9	10
Very Poorly									Very Well

RECENTLY how is your overall functioning, and emotional and psychological well-being?

1	2	3	4	5	6	7	8	9	10
Very Poorly									Very Well

Please check any of the following symptoms, feelings or behaviors that you have experienced. Check the **FIRST** column if you have had this experience in the **LAST SIX MONTHS**. Check the **SECOND** column if you have **EVER** had the experience.

Last Six Months	Ever	
_____	_____	Excessive or uncontrollable outburst of anger or violence toward others
_____	_____	Low mood
_____	_____	Low energy, low joy or interest in life
_____	_____	Frequent crying or sadness

Last Six Months	Ever	
_____	_____	Interrupted sleep, difficulty falling asleep, or difficulty getting up
_____	_____	Increased energy, low need for sleep
_____	_____	Anxiety, agitation, or fear
_____	_____	Weight loss or weight gain
_____	_____	Persistent thoughts or plans about killing yourself
_____	_____	Occasions where you hurt yourself (cutting or hitting yourself, etc)
_____	_____	Panic or anxiety attacks
_____	_____	Fear of leaving your house or extreme fear in social situations
_____	_____	Abuse or illegal drugs or prescribed medications
_____	_____	A Partner who hits me or is an addict or alcoholic
_____	_____	Compulsive overeating, binging, purging, not eating, or over use of exercise or Laxatives
_____	_____	Loss of control over thoughts, strange thoughts, hearing voices or seeing things or amnesia for recent events
_____	_____	Being sexually abused or molested, having memories of past sexual abuse or rape
_____	_____	Being physically abused or having memories of past physical abuse
_____	_____	Compulsive acts or obsessive thoughts
_____	_____	Sexual problems or dissatisfactions
_____	_____	Very low self-esteem, feelings of guilt, shame, self-hatred
_____	_____	Uncertainty about sexual orientation
_____	_____	Persistent loneliness, shyness, self-consciousness
_____	_____	Problems in relationships:

_____ Collaboration	_____ Conflict	_____ Communication
_____ Criticism	_____ Defensiveness	_____ Contempt
_____ Listening	_____ Withdrawal	_____ Affair(s)

_____	_____	Problems coping with the end of a relationship
_____	_____	Intrusive negative thoughts or unpleasant physical sensations
_____	_____	Feeling as though you are unreal, or as though body parts are unreal, or you are existing in an unreal world, or as though you step back and watch yourself.

Last Six Months	Ever	
_____	_____	Feeling as though the world and people around you are strange or unfamiliar
_____	_____	A sense that there are time gaps in your memory; you can't recall periods of time in your day or week; or no memory for periods of years in your life.
_____	_____	Feeling confused or conflicted about your sense of who you are
_____	_____	Hearing voices in your head that disagree, tell you what to do, and make it hard for you to think clearly sometimes.

F. Your current employer

Employer: _____ Address: _____

Work phone: _____ or other means of communication _____

Calls will be discreet, but please indicate any restrictions: _____

G. Emergency information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: _____ Phone: _____ Relationship: _____

Address: _____

Significant other/nearest friend or relative not residing with you: _____

H. Family-of-origin history

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

I. Marital/relationship history

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

J. Significant nonmarital relationships

	Name of other person	Person's age	Your age when started	His/Her age when started	Reasons for ending when ended
First					
Second					
Current					

K. Children Indicate those from a previous marriage or relationship with "P" in the last column. Indicate step children with "S"

Name	Current age	Sex	School	Grade	Adjustment problems?	P? S?

L. Your education and training

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

M. Employment and military experiences

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

N. Is there any other information you think we should know?_____

_____

Signature:_____ Date: _____
(if 18 or older)

Parent/Guardian: _____ Date: _____

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.