Psychological Consultants
Northgate Center
1210 ½ 7th Street NW, Suite 216
Rochester, MN 55901
www.psychologicalconsultants1.com
Office: (507) 252-9292 **Fax: (507) 252-9203**

Date Today: _____

Client Name(s): _____ Preferred Name (s): _____

Local Address: _____ City: _____ State: _____ Zip: _____

Permanent Address: _____ _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Date of Birth: _____ Age: _____

Years of Education: _____ Occupation: _____ Gender: _____

Employer's Name: _____ Marital Status: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Insurance Information:

Primary Insurance Name: _____ **Policy ID #:** _____

Primary Ins. Address: _____ City: _____ State: _____ Zip: _____

Policy Holder's Social Security #: _____ Policy Holder's Date of Birth: _____

Secondary Insurance Name: _____ **Policy ID #:** _____

Secondary Ins. Address: _____ City: _____ State: _____ Zip: _____

Policy Holder's Social Security #: _____ Policy Holder's Date of Birth: _____

Payment Options:

How do you intend to pay for your services today? Credit Card Cash Check

Credit Card Type: _____ Credit Card Number: _____

Name exactly as it appears on credit card (please print): _____

Credit Card Expiration Date (mm/yy): _____ **Authorized Signature:** _____

How did you hear of us? _____ Referred by? _____

TWO PEOPLE TO CONTACT IN CASE OF EMERGENCY

Name: _____ Relationship to you: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

*** Does this person know of this visit? Yes No**

Name: _____ Relationship to you: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

*** Does this person know of this visit? Yes No**

**** In the event of an emergency, do I have permission to contact these individuals? Yes No**

MEDICAL INFORMATION

Primary Care Physician: _____ **Address:** _____

Date of Last Physical Exam: _____ Treating facility: _____

Allergies: _____

Chronic Physical Conditions: _____

Current Medication(s)(if not enough room, list on back of page):

Name of Medication: _____ Dosage: _____ Start Date: _____

Name of Medication: _____ Dosage: _____ Start Date: _____

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Have you ever been treated for a serious illness, injury or head trauma? Yes No

If yes, please explain: _____

Circle any medical problems you are currently experiencing:

Arthritis	Heart Disease	Lung Disease	Stroke
Asthma	Heartburn	Menopause	Sexual Difficulties
Bladder problems	High Blood Pressure	Osteoporosis	Seizures
Cancer	High Cholesterol	Other Male/Female Disease	Skin Disease/Disorder
Diabetes: Type I/II	HIV Positive		Thyroid Problems
Glaucoma	Irregular Periods	Polycystic Ovary Disease	Tuberculosis
Headaches	Kidney Disease		
Head Injury	Kidney Problems	Stomach Problems	Ulcer

Other: _____

PREVIOUS PSYCHOLOGICAL EVALUATIONS, COUNSELING, OR TREATMENTS

Treating Provider: _____ Dates of service From: _____ To: _____

Reason(s): _____

Was it Helpful? Yes No If not, why? _____

Treating Provider: _____ Dates of service From: _____ To: _____

Reason(s): _____

Was it Helpful? Yes No If not, why? _____

Personal History

What is your mother's name: _____ Is she still alive? **Yes No**

What is your father's name: _____ Is he still alive? **Yes No**

What is your parents' marital status? Married Separated Divorced

If your parents are separated or divorced, how old were you when they separated/divorced? _____

Where and by whom were you raised? _____

List the first names and ages of your siblings: **Name** **Age**

_____

_____

_____

_____

Describe how it was/is growing up in your family: _____

_____

_____

What one word best describes your family when you were a child? _____

How many people currently live in your household (including yourself)? _____

How many children do you have? _____

List the first names and ages: **Name** **Age**

_____

_____

_____

_____

Please describe the problem(s) for which you are seeking help: _____

_____

_____

CLIENT DATA FORM (CONT'D)

When and how did your current problem(s) begin? _____

_____

_____

_____

_____

From the list below, circle all problem areas that pertain to you at this time:

Academic/School	Eating Disorder	Intimacy	Parenting
Alcohol Use	Employment	Legal	Physical Health/Disability
Anger	Family Conflict	Marital/Relationship	Religious/Spiritual Concerns
Anxiety	Financial	Mental Health/Disability	Sexuality
Criminal Behavior	Gambling	Mental Illness	Socialization
Drug Abuse	Grief/Loss	Mood	Victim of Abuse

Other: _____

Please circle all of the symptoms you have experienced in the *last two weeks*.

Depressed mood	Irritable/Angry	Shortness of breath	Violent when angry
Muscle tension	Trouble keeping Friends	Increased worry	Decreased mood
Change in appetite		Over eating	Trouble forming friendships
Sleep problems	Feeling worthless	Sweating	
Loss of energy	Feeling defensive	Easily Distracted	Angry outbursts
Mind going blank	Unable to follow through with goals	Feeling restless	Repetitive thoughts
Trembling/shaking		Trouble performing job	Feeling anxious
Dizziness	Feeling numb	Avoiding certain foods	Seeing things others don't see
Elevated mood	Racing heart	Feeling hopeless	
Hearing voices	Trouble Concentrating	Tire easily	Thoughts of death
Feeling suspicious	Binging	Trouble making decisions	Nausea/Stomach Distress
Feeling rageful	Mood swings		
Repetitive behaviors	Angry Outbursts	Excessive exercise	Decreased need for sleep
Racing thoughts	Impulsiveness	Feeling stressed	
Restricting food	Feeling Paranoid	More talkative	Using diuretics

CLIENT DATA FORM (CONT'D)

Have you ever attempted suicide? **Yes** **No**

If yes, list at what age(s): _____

Are you currently feeling Suicidal? **Yes** **No**

Please enter check marks where appropriate to indicate family members who have experienced mental health concerns.

Illness	Self	Father	Mother	Brother/Sister	Grandparent	Other
Depression						
Anxiety						
Alcoholism						
Schizophrenia						
Bipolar Disorder						
Drug Addiction						
Attention Deficit Disorder						
Eating Disorder						
Post-Traumatic Stress						
Obsessive/Compulsive						
Mania						
Committed Suicide						
Committed Homicide						

Other: _____

Have you been either the **victim** and/or **perpetrator** of sexual abuse?

Are you currently experiencing any legal difficulties? **Yes** **No**

If yes, please explain: _____

_____

Are you currently experiencing any job difficulties? **Yes** **No**

If yes, please explain: _____

_____

Do you smoke? **Yes** **No** If yes, how much per day? _____

Do you wish to quit? **Yes** **No**

CLIENT DATA FORM (CONT'D)

How much caffeine do you consume daily? _____

How much alcohol do you consume? Daily? _____ Weekly? _____
Last use of alcohol? _____

What street drugs do you, or have you used? _____
Last use of street drugs? _____

Have you ever thought that you should cut down on your drinking and or drug use? **Yes No**
In the past year, have you ever had people annoy you by complaining about your drinking or drug use? **Yes No**

In the past year, have you ever used alcohol or street drugs first thing in the morning to steady your nerves or get rid of a hangover, or to get your day started? **Yes No**

Have you ever been charged with a DUI or DWI? **Yes No**
If yes, please list date(s): Month/Year _____
Month/Year _____
Month/Year _____
Month/Year _____

List all inpatient and outpatient chemical dependency treatments

Facility _____ Month/Year _____ Completed? _____
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Facility _____ Month/Year _____ Completed? _____
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Patient Signature: _____