Psychological Consultants

Northgate Center
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Today Date: ____________________

Client Name(s) ____ Preferred Name (s): ____________________

Local Address: ______________________________ City: __________ State: ______ Zip: ________

Permanent Address: ______________________________ City: __________ State: ______ Zip: ________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Social Security #: ______________ Date of Birth: ______________ Age: ______________

Years of Education: __________ Occupation: ____________________ Gender: M F

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: __________

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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**

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?

List all inpatient and outpatient mental health treatments

Facility	Month/Year	Completed?

Patient Signature: ______________________________