COMPREHENSIVE PSYCHOLOGICAL SERVICES, P.C.

INFORMATION AND HISTORY

I. Identifying Information

Referred by:_____

Name:_____ Date:_____

Date of Birth:_____ Age:_____ Gender: _____ Social Security #: _____

Address: _____(city)_____(zip)_____

Phone: _____ Alternate Phone: _____

Level of Education:_____ Job Title:_____

Marital Status:_____ Spouse's name (if applicable):_____DOB.:_____

Emergency Contact Person:_____ Phone:_____

II. Insurance

Insurance:_____ Subscriber:_____ DOB:_____

Contract/Member ID:_____ Relationship to Client: _____

Group Number: _____ Social Security #: _____

Secondary Insurance:_____ Subscriber:_____ DOB:_____

Contract/Member ID:_____ Relationship to Client: _____

Group Number:_____ Social Security #: _____

III. Clinical Information

Please explain why you are seeking psychological services at this time: _____

_____

_____

Have you received outpatient psychological services in the past? Y N

Please describe: _____

Have you ever been hospitalized for psychiatric reasons? Y N

Please describe: _____

Is there a history of emotional problems, mood disorders, or psychiatric illness in your family? Y N

Please describe: _____

Are you currently having any thoughts of hurting yourself or anyone else? Y N

Please describe: _____

Have you recently had any changes in your:
marital status Y N Please describe: _____
employment Y N Please describe: _____
residence Y N Please describe: _____

Do you:	feel nervous	Y N	have any sexual problems	Y N
	feel depressed	Y N	find it hard to make decisions	Y N
	worry a lot	Y N	lose your temper frequently	Y N
	use marijuana	Y N	feel bored with your life	Y N
	use hard drugs	Y N	engage in compulsive behaviors	Y N

IV. Substance Abuse History

Has anyone ever recommended that you cut back or stop drinking? Y N

Have you ever felt annoyed or angry if someone commented on your drinking? Y N

Have there been times when you felt guilty about, or regretted, things that occurred because of your drinking? Y N

Have you ever used alcohol to help you get started in the morning, or to steady your nerves? Y N

Have you ever been in residential substance abuse treatment? Y N

Is there a history of drug or alcohol abuse in your family? Y N

How much alcohol do you consume per week? _____ Has this increased recently? Y N

V. General Health History

How is your overall health now? poor fair good excellent

How has it been most of your life? poor fair good excellent

In the past 6 months:

have you been treated by a physician for any illnesses? Y N
please describe:_____

has your appetite changed? decreased increased no change

has your weight changed recently? lost_____lbs gained_____lbs no change

has your overall level of energy changed? decreased increased no change

Do you usually have trouble sleeping? Y N

How much do you exercise? little or none less than I need all that I need

Do you smoke? Y _____ (amount each day) N

Are you currently taking any medications? Y N

Please list medications and dosages:_____

Your physician's name and phone number: _____

VI. Illnesses and Medical Problems

Please check (✔) any of the following illnesses and medical problems you have had and indicate the year when each started or occurred. If you are uncertain when an illness started, please give an approximate year.

illness	✔	year	illness	✔	year
Glaucoma			Diverticulosis		
Eye disorder			Colitis		
Ulcers			Yellow jaundice		
Deafness			Liver problems		
Ringing in the ears			Gall bladder problems		
Bronchitis			Hernia		
Emphysema			Kidney or Bladder Disease		
Pneumonia			Prostate problems		
Allergies			Migraine headaches		
Asthma			Epilepsy		
Tuberculosis			Head injury		
Other lung problems			Stroke		
High blood pressure			Seizure disorder		
Heart attack			Arthritis		
High cholesterol			Cancer		
Arteriosclerosis			Diabetes		
Heart murmur			Hepatitis		
Other heart condition			Measles		
Mononucleosis			Other		

Client Signature:_____ **Date:**_____