SMART HEALTH PSYCHOLOGY
PATIENT INFORMATION AND BACKGROUND

Please provide the following information on this this form and bring it to your first session.

Name: _____ (Last) _____(First, M.I.)

Address:_____

Home: ( ) _____ Cell: ( ) _____ Ok to leave message? ▫Yes ▫No

Email: _____
(Email is not considered a confidential form of communication, and is used for scheduling only)

Referred by: _____Birth Date: _____ /_____ /_____ Age: _____

Gender: _____ Racial/ cultural/ religious Identification:_____

Relationship Status:
▫ Single, Never Married ▫ Married (_____ years) ▫ Living as Married (_____ years)
▫ Separated (_____ years) ▫ Divorced (_____ years) ▫ Widowed (_____ years)

Names and ages of children (if any), and living in home? (Y/N)

_____

_____

Are others living in your home? ▫ Y ▫ N Name/ relationship: _____

Type/ Place of employment: _____

Emergency Contact: _____ Phone: ( ) _____ Relationship: _____

PRESENTING PROBLEMS AND CONCERNS

Describe what brought you here today:

_____

_____

What significant life changes or stressful events have you experienced recently:

_____

_____

Describe what you would like to achieve through therapy:

_____

_____

Are you currently experiencing overwhelming sadness, grief or depression? ▫ No ▫ Yes
If yes, for approximately how long? _____
Do you have a history of depression? ▫ No ▫ Yes Had you sought therapy for this? ▫ No ▫ Yes

Are you currently experiencing anxiety, panic attacks or phobias? ▫ No ▫ Yes Since when? _____
Do you have a history of anxiety? ▫ No ▫ Yes Had you sought therapy for this? ▫ No ▫ Yes
Are you experiencing acute or chronic pain? ▫ No ▫ Yes If yes, please describe? _____

Have you recently had thoughts about or attempted to hurt yourself? ▫ No ▫ Yes
Is there a history of suicide attempts or efforts to hurt yourself? ▫ No ▫ Yes
Have you recently had thoughts about or attempted to hurt someone else? ▫ No ▫ Yes

THERAPY HISTORY
Have you ever seen a therapist or psychiatrist? No ▫ Yes
Dates/ details: _____
Have you ever been prescribed psychiatric medication? ▫ Yes ▫ No
Medications/ approx. dates: _____

GENERAL HEALTH
Current health concerns: _____

How are your current sleeping habits? ▫ Poor ▫Unsatisfactory ▫ Satisfactory ▫ Good ▫ Very good
Please describe current sleep concerns: _____

Frequency/ type exercise: _____ Recent changes in appetite _____

Alcoholic beverages/ week?
▫ 3+ day, most days ▫ 1-2 drinks/ day ▫ 3-5 drinks/ week ▫ 1-2 drinks/ week ▫ Rarely/never

How many cigarettes do you smoke/ day?
▫ 20+ day ▫ 5-20/ day ▫ < 5 day ▫ former smoker, not current ▫ never smoker

How often do you engage recreational drug use? ▫ Daily ▫ Weekly ▫ Infrequently ▫ Never

Have you experienced any of the following medical conditions during your lifetime?

▫ Chronic pain	▫ Seizures	▫ Vision problems
▫ Cancer	▫ Hearing problems	▫ Asthma
▫ Heart disease	▫ Sleep disorder	▫ Diabetes
▫ Headaches	▫ Stomach aches	▫ Other: _____
▫ Serious accident	▫ Head injury	

Please identify if there is a <u>family history</u> of any of the following:

▫ Alcohol/Substance Abuse	▫ Domestic Violence	▫ Suicide Attempts
▫ Anxiety	▫ Eating Disorders	
▫ Depression	▫ Schizophrenia	

SMART HEALTH PSYCHOLOGY

Please check all of the behaviors and symptoms that are affecting you currently:

	Never/Rarely	Occasionally	Often	Always/ nearly always
Alcohol/drug use				
Anxiety/worry				
Boredom				
Change in appetite				
Computer addiction				
Crying spells				
Distractibility				
Eating problems				
Excessive energy				
Fatigue				
Guilt/shame				
Hopelessness				
Hyperactivity				
Impulsivity				
Lack of motivation				
Loneliness				
Loss of pleasure/interest				
Low self worth				
Nightmares				
Poor memory/confusion				
Problems with pornography				
Racing thoughts				
Recurring, disturbing memories				
Relationship problems				
Sadness/depression				
Seasonal mood changes				
Self-harm behaviors				
Sexual problems				
Sleep problems				
Thoughts of death				
Wide mood swings				
Withdrawal from people				
Work/school problems				

Are your problems affecting any of the following?

	Not at all	Mildly	Moderately	Significantly
Handling everyday tasks				
Work/School				
Recreational activities				
Self esteem				
Housing				
Sexual activity				
Relationships				
Legal matters				
Health				
Finances				