SMART HEALTH PSYCHOLOGY

PATIENT INFORMATION AND BACKGROUND

Please provide the following information on this this form and bring it to your first session. Information you provide here is protected as confidential information.

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

Address:_____ (Street and Number)

_____ (City, State, Zip)

Home Phone: ( ) _____ May we leave a message? ▫Yes ▫No

Cell/Other Phone: ( ) _____ May we leave a message? ▫Yes ▫No

Email: _____ May we email you? ▫Yes ▫No
(Please note: Email is not considered to be a confidential form of communication, and is used for scheduling purposes only)

Referred by (if any): _____

Birth Date: _____ /_____ /_____ Age: _____ Gender: ▫ Male ▫ Female

Racial and Cultural Identification: _____
Religious Identification: _____

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

Names of children (if any): Age(s) Living in home (Y/N)
_____ _____ _____
_____ _____ _____
_____ _____ _____
Are there others living in your home? ▫ Y ▫ N Name/ relationship: _____

Type/ Place of employment: _____

Emergency Contact Information
Name: _____
Phone: ( ) _____ Relationship to you: _____

Primary Care Physician Date of last physical exam: _____
Current Physician: _____
Physician Address: _____
Physician Phone Number: _____Physician Fax Number: _____

SMART HEALTH PSYCHOLOGY

Adult Intake Form

Name: _____ Date: _____

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
If yes, when did you begin experiencing this? _____
Do you have a history of anxiety? ▫ No ▫ Yes Had you sought therapy for this? ▫ No ▫ Yes

Are you currently 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

COUNSELING/ THERAPY HISTORY
Have you ever received mental health services (psychotherapy, psychiatric services, etc.)?
▫ No ▫ Yes Previous therapist/practitioner(s)/ dates: _____
_____

Have you ever been prescribed psychiatric medication? ▫ Yes ▫ No
Please list medications and dates you had taken: _____
_____

GENERAL HEALTH

Please describe your current health concerns: _____

How would you rate your current physical health?
▫ Poor ▫ Unsatisfactory ▫ Satisfactory ▫ Good ▫ Very good

Are you currently taking any prescription medication? ▫ Yes ▫ No
Please list: _____

How would you rate your current sleeping habits?
▫ Poor ▫Unsatisfactory ▫ Satisfactory ▫ Good ▫ Very good

Please describe current sleep concerns: _____

Times/ week you generally exercise: _____ Social/leisure activities:_____

How is your appetite? Recent changes? _____

How much alcohol do you drink each 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

From what doctors/ medical specialists are you currently receiving care? _____

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

▫ Allergies
▫ Chronic pain
▫ Cancer
▫ Heart disease
▫ Dizziness/fainting
▫ Headaches
▫ Serious accident
▫ Seizures
▫ Hearing problems
▫ Sleep disorder
▫ Stomach aches
▫ Head injury
▫ Vision problems
▫ Miscarriage
▫ Asthma
▫ Surgery
▫ Meningitis
▫ Diabetes
▫ Other: _____

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

▫ Alcohol/Substance Abuse
▫ Anxiety
▫ Depression
▫ Domestic Violence
▫ Eating Disorders
▫ Obesity
▫ Obsessive Compulsive Behavior
▫ Schizophrenia
▫ Suicide Attempts

SMART HEALTH PSYCHOLOGY

SYMPTOM CHECKLIST

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				
Gambling problems				
Guilt/shame				
Hopelessness				
Hygiene				
Hyperactivity				
Impulsivity				
Lack of motivation				
Loneliness				
Loss of pleasure/interest				
Low self worth				
Nightmares				
Parenting problems				
Poor memory/confusion				
Problems with pornography				
Racing thoughts				

	Never/Rarely	Occasionally	Often	Always/ nearly always
Recurring, disturbing memories				
Relationship problems				
Sadness/depression				
Seasonal mood changes				
Self-harm behaviors				
Sexual problems				
Sleep problems				
Suspicion/paranoia				
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				