Melissa Korland, Ph.D.
Background Information- Adult

First Name: ______________________________ Middle Initial: _______ Last Name: ____________________________
Age: ____________ Birth Date: ____/____/_______ Gender: Male / Female
Home address: ____
Occupation:____________________________________ Employer:______________________________________
Home Phone: ______________________Cell Phone:____________________ Business Phone:_________________
Preferred phone number for contact: __________________________________

Briefly describe the reason for this appointment: ____
____
____
Please list any treatment goals or expectations that you have: ____
____
____

Family Composition:
List immediate family and significant relationships. List all children, including stepchildren.

Name	Gender	Relationship	Age	Live in your household?
______________________________	M / F	_____________________	_____________	Yes / No
______________________________	M / F	_____________________	_____________	Yes / No
______________________________	M / F	_____________________	_____________	Yes / No
______________________________	M / F	_____________________	_____________	Yes / No
______________________________	M / F	_____________________	_____________	Yes / No
______________________________	M / F	_____________________	_____________	Yes / No

Marital and Relationship History:
Please circle and comment, if applicable.
Single How long?_______
In relationship now How long? ______
Married How long? ______ Past marriages? ____
Separated How long? ______
Divorced How long? ______ Past divorces? ____
Widowed How long? ______
Additional comment or info:____

Partner's name:_________________________________ Age:________ Partner's Occupation:_________________________

Educational History:
Please list your highest level of education completed (for example: high school graduate): _________________________________
History of learning or behavioral problems in school? ____
History of special education or support services? ____

Medical History
Please list any current medical problems: ____
____
Please list any past serious illness, injuries, or surgeries: ____
____
Please list any medications you are taking (including dosage if known): ____
____
Do you have any significant medical problems in your family? __________ If yes, please describe: __________________________
____
Additional comments: ____
____
____

Mental Health History

Please list any previous mental health services (outpatient and/or inpatient) that you have received:

Provider/Agency	Dates	Reason
___________________________	___________________	____
___________________________	___________________	____
___________________________	___________________	____
___________________________	___________________	____
___________________________	___________________	____

Please list any psychiatric/psychotropic medication you are currently taking or have been prescribed in the past:

Medication	Dosage	Dates	Reason	Prescribed By
___________________	___________	____________	_____________________	______________________
___________________	___________	____________	_____________________	______________________
___________________	___________	____________	_____________________	______________________
___________________	___________	____________	_____________________	______________________

Additional Comments: ____
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