Weitman Psychological Services, P.C.

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Client Information

Today's Date: _____

Name _____ Date of Birth_____Age _____ Gender: M F

Address _____City _____ State _____ Zip_____

Ethnicity/Other Minority Affiliation(s)_____

	Okay to leave Messages? Yes	No	Primary Contact Number?
Home Phone _____	☐	☐	☐
Work Phone _____	☐	☐	☐
Cell Phone:_____	☐	☐	☐

Email _____Okay to Email? Yes ☐ No ☐ (I agree to email policy by checking "yes")

Relational Status _____ Name of Spouse/Partner _____

Length of Current relationship _____

Occupation _____ Employer _____

How long at current job? _____ Level of Education:_____ Years

In Case of Emergency Notify: Name _____Relationship to Client: _____

Phone _____ Address _____City _____State ____Zip_____

Are You Now Under a Doctor's Care?_____If yes, Doctor's name: _____

Reason for Doctor's Care: _____

Who referred you to Dr. Weitman? _____

Insurance Company _____ Policy number _____Group number _____

Insurance Company _____ Policy number _____Group number _____

Notes:

Presenting Problems and Concerns

Describe the problem that brought you here today: _____

_____

_____

Please check all of the behaviors and symptoms you consider problematic:

□ Distractibility	□ Change in appetite	□ Racing thoughts
□ Hyperactivity	□ Lack of motivation	□ Excessive energy
□ Impulsivity	□ Withdrawal from people	□ Wide mood swings
□ Boredom	□ Anxiety/worry	□ Sleep problems
□ Poor memory	□ Panic/anxiety attacks	□ Easily startled
□ Confusion	□ Fear away from home	□ Nightmares
□ Seasonal Mood changes	□ Social discomfort	□ Eating problems
□ Sadness/Depression	□ Obsessive thoughts	□ Gambling problems
□ Loss of pleasure/interest	□ Compulsive behavior	□ Computer addiction
□ Hopelessness	□ Aggression/fights	□ Problems with pornography
□ Thoughts of death	□ Frequent Arguments	□ Parenting problems
□ Self-harm behaviors	□ Irritability/anger	□ Sexual problems
□ Crying spells	□ Homicidal Thoughts	□ Relationship problems
□ Loneliness	□ Flashbacks	□ Work/school problems
□ Low self worth	□ Hearing voices	□ Alcohol/drug use
□ Guilt/Shame	□ Visual hallucinations	□ Other: _____
□ Fatigue	□ Suspicion/paranoia	

Are your problems affecting any of the following?

☐ Handling everyday tasks	☐ Self Esteem	☐ Relationships	☐ Hygiene
☐ Work/School	☐ Housing	☐ Legal matters	☐ Finances
☐ Recreational activities	☐ Sexual activity	☐ Health	

When did these problems begin? _____

What have you tried to solve your problems? _____

_____

_____

_____

□ Yes □ No Have you ever had thoughts, made statements, or attempted to hurt yourself or someone else? If so, please describe:

_____

_____

Family and Developmental History

RELATIONSHIP	*FIRST NAME*	*AGE*	*QUALITY OF RELATIONSHIP*
Mother			
Father			
Stepmother			
Stepfather			
Siblings			
Spouse/partner			
Children			

Family Mental Health Problems	*Who?*
Hyperactivity	
Sexually Abused	
Depression	
Bipolar (Manic) Depression	
Suicide	
Anxiety	
Panic Attacks	
Obsessive-Compulsive	
Anger/Abuse	
Schizophrenia	
Eating Disorder	
Alcohol Abuse	
Drug Abuse	

☐ Parents legally married or living together ☐ Mother remarried number of times _____

☐ Parents temporarily separated ☐ Father remarried number of times _____

☐ Parents divorced or permanently separated ☐ Parent(s) deceased Who? _____

Please check if you have experienced any of the following types of trauma or loss:

☐ Emotional abuse ☐ Neglect ☐ Lived in a foster home ☐ Parent illness ☐ Sexual abuse ☐ Violence in the home

☐ Multiple family moves ☐ Loss of a loved one ☐ Financial problems ☐ Physical abuse ☐Parent substance abuse

☐ *Work related traumatic incidents. Please briefly list type of each incident, your role, and year it occurred:*

_____

_____

_____

_____

Previous Mental Health Treatment

Type of Treatment	When?	Provider	Reason for treatment
Outpatient Treatment			
Medication (mental health)			
Psychiatric Hospitalization			
Drug/Alcohol Treatment			
Self-help/Support Groups			

Medical Information

Date of most recent physical exam:_____

Have you ever experienced the following medical conditions during your lifetime?

☐ Allergies ☐ Asthma ☐ Headaches ☐ Stomach aches

☐ Chronic pain ☐ Surgery ☐ Serious accident ☐ Head Injury

☐ Meningitis ☐ Seizures ☐ Vision problems ☐ Dizziness/fainting

☐ High fevers ☐ Diabetes ☐ Hearing problems ☐ Sleep disorder

☐ Fibromyalgia ☐ Significant memory problems ☐ Other _____

Please list any current or significant past health concerns: _____

_____

_____

Current prescription and over-the-counter medications: ☐ None (Please attach additional sheet if necessary)

MEDICATION	DOSAGE	DATE FIRST PRESCRIBED	PRESCRIBED BY

Allergies and/or adverse reactions to medications: ☐ None If yes, please list: _____

_____

Notes:

Substance Use History

SUBSTANCE TYPE	Y	N	CURRENT FREQUENCY (DAILY/MONTH/YEAR)	AMOUNT	PAST USE (MORE THAN 6 MOS AGO
Tobacco					
Caffeine					
Alcohol					
Marijuana					
Cocaine/Crack					
Ecstasy					
Heroin					
Inhalants					
Methamphetamines					
Pain Killers					
PCP/LSD					
Steroids					
Tranquilizers					

How much alcohol do you drink on average? _____ drinks ☐per day ☐per week ☐per month ☐per year

Has anyone ever told you they were concerned about your drinking? ☐ Yes ☐ No

Have you ever failed to meet commitments because of your drinking? ☐ Yes ☐ No

Interpersonal/Social/Cultural Information

Please describe your social support network (check all that apply)

☐ Family ☐ Neighbors ☐ Friends ☐ Co-workers ☐ Support/self-help group

☐ Community Group ☐ Religious/Spiritual Center ☐ Other :_____

Please describe your strengths, skills, and talents, and how you manage stress:_____

_____

_____

Please describe hobbies, interests (i.e. reading, fitness, etc): _____

_____

_____

Notes:

Military Service

☐ Yes ☐ No Have you been or are you in the military? Branch:_____ Date of Discharge:_____

☐ Yes ☐ No Were you in combat?

Legal

☐ Yes ☐ No Are you currently involved in any legal proceeding? Please explain: _____

Please include any additional information that you think is important for me to know: _____

Thank you for taking the time to fill out this form.

Notes: