OPTIMAL HEALTH Psychological Services

Patient Information Form
<u>All Information Documented here is Confidential</u>

Date:____________________

A. General Information

Name of patient:___________________Date of Birth:_______________________Age:________

Home Address:____Apt:_____________________

City:_______________________________________State:_____________Zip:_______________

Home Phone:_____________Cell Phone:_____________________E-mail:____________

Call/Text Restrictions?____

Primary care doctor:________________________________Phone:____________

Employer:____________________________Address:__________________________________

Work Phone:___________________Call Restrictions:__________________________________

Marital status: _______________________ Children/ages:______________________________

How did you hear about OPTIMAL HEALTH? (Please check one)

Advertisement:____________Website:___________Online Search:______Word of mouth:_____

Who referred you to our office? ____

Please describe in brief the reason(s) for your visit today_________________________________

____

B. History and Treatment:

Has patient ever received psychological, psychiatric, drug, or alcohol treatment, or counseling services before? **Yes / No**

Date(s) Circumstances

____

____

____

Has patient ever taken medications for psychiatric or emotional problems? **Yes / No**

Medication name Dosage Circumstances Date(s)

____

____

____

Has patient ever experienced verbal, emotional, physical, or sexual abuse? **Yes / No**

Is this something you would like to address in therapy? **Yes / No**

Does patient drink? **Yes / No** How much?______________________________
How often?__________________________Type?____________________________________

Does patient use illicit drugs? **Yes / No** How Much?______________________________
How often?__________________________Type?____________________________________

Has patient been diagnosed with medical illness/s? **Yes/No**

Medical illness	Medications	Provider	Date(s)

For Children and Adolescents Only

Natural Child**: Yes/No** If adopted, at what age**:** ____________ Foster since:_____________

Parents Names (include step-parents, foster parents)

____

Comments about custody and visitation (if applicable)

____

Developmental and Health History:

Mother used during pregnancy: Alcohol_________ Drugs__________ Cigarettes____________

Delivery: Normal_____ Breech______ Cesarean_________ Full-Term_____________________

Premature_______ If premature, number of weeks___________________ NICU stay?________

Birth Weight__________ Interventions after birth (oxygen, blood transfusions, exc.) _________

____

At approximately what age did child:

Walk __________ Said first word _____________ Used 2-Word phrases__________________

Understood and followed simple directions____

Toilet Trained_____________ Did child cry excessively?___________Rarely Cried?________

Any head injuries or loss of consciousness? **Yes/No**

Children and Adolescents only (continued)

History of serious illness, injury, handicaps, or hospitalizations? No_____ Yes (Describe and give dates)____

History of self-harm or suicidal ideation:____

Do you think your child's use of chemicals is a problem? **No**:_____ **Yes**:______

Type: Alcohol:_____ Tobacco:_____ Marijuana:______ Other drugs:____________________

Educational History:

Present School:____________________________________ Grade:_______________

Has child ever repeated any grade? **Yes/No**

Does child have any special accommodations? **Yes/No** **If yes please explain:**

____

Please describe academic or other problems your child has had in school:

____

____

What are your child's strengths?____

What are your child's hobbies/extracurricular activities?

____

How is your child disciplined: ____

Has your child witnessed domestic violence? **Yes/No**

How much exercise a day does child get?____

How much sleep at night does child get? ____

C. Legal Information:
Is patient involved in a legal case? **Yes / No**
*****If yes, please review our policy regarding legal cases.

Are there any other legal involvements we should know about? **Yes / No**
Please Explain:____

____

____

Is there anything else that is important for your therapist to know about the patient, and that has not been written about on this form? **Yes / No**

Please Explain:____

____

____

____

D. Concerns Checklist:
Please mark all the items that apply to you:

- ◻ Abuse
- ◻ Alcohol use
- ◻ Anger
- ◻ Anxiety
- ◻ Career concerns
- ◻ Childhood issues
- ◻ Codependence
- ◻ Concentration
- ◻ Confusion
- ◻ Compulsions
- ◻ Delusions
- ◻ Dependence
- ◻ Depression
- ◻ Divorce, separation
- ◻ Drug use
- ◻ Eating problems
- ◻ Emptiness
- ◻ Failure
- ◻ Fatigue
- ◻ Fears
- ◻ Finances
- ◻ Friendships
- ◻ Gambling
- ◻ Grief
- ◻ Guilt
- ◻ Headaches
- ◻ Health
- ◻ Indecision
- ◻ Interpersonal conflicts
- ◻ Impulsiveness
- ◻ Loneliness
- ◻ Memory problems
- ◻ Mood swings
- ◻ Nervousness
- ◻ Obsessions
- ◻ Oversensitivity to rejection
- ◻ Panic attacks
- ◻ Parenting concerns
- ◻ Perfectionism
- ◻ Pessimism
- ◻ Procrastination
- ◻ Relationships problems
- ◻ School problems
- ◻ Self-esteem
- ◻ Self-neglect
- ◻ Sexual issues
- ◻ Shyness
- ◻ Sleep problems
- ◻ Smoking
- ◻ Spiritual issues
- ◻ Stress
- ◻ Suspiciousness
- ◻ Suicidal thoughts
- ◻ Temper problems
- ◻ Weight
- ◻ Withdrawal
- ◻ Work problems
- ◻ Other:

- □ Other:
- □ Other: