OPTIMAL HEALTH Psychological Services

**Patient Information Form**
**All Information Documented here is Confidential**

Date:_____

**A. General Information**

Name:_____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:**

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

| Date(s) | Circumstances |
|---|---|
| | |
| | |
| | |

Have you ever taken medications for psychiatric or emotional problems? **Yes / No**

| Medication name | Dosage | Circumstances | Date(s) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Have you ever experienced verbal, emotional, physical, or sexual abuse? **Yes / No**

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

Do you drink? Yes / No How much?_____
How often?_____ Type?_____

Do you use illicit drugs? Yes / No How Much?_____
How often?_____ Type?_____

Have you been diagnosed with medical illness/s? **Yes/No**

| Medical illness | Medications | Provider | Date(s) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**C. Legal Information:**
Are you 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, and that you have not 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: