Patient Identification and History

Date:

Risa Newell, Ph.D., L.L.C., Licensed Clinical Psychologist
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Thank you for taking the time to complete this form – a thorough review of important parts of your life that are relevant to my understanding of who you are. The following questions are personal and sensitive in nature and will remain strictly confidential and secure. By completing your Identification and History, you will provide valuable information for the therapeutic process and expedite our important work ahead.

* Signature required below

Identifying Information:

Name*: DOB*:

Ethnicity: Living Situation:

Spouse / Partner: DOB:

Children's Names / Ages:

Important others you consider family:

Retired? Yes No Stay at home? Yes No

Occupation: Employer:

Emergency Contact: Relationship:

Contact Telephone: Email Address:

Primary Care Physician:

Name: Last Visit:

Telephone: Fax:

Consent to Communicate: Yes No

* Signature (required) Date

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Psychiatrist:

Name: Last Visit:

Telephone: Fax:

Consent to communicate: Yes No

* Signature (required) Date

Current Medications: I am attaching my Medication List instead

Psychiatric Medication

Any concerns or troubling Side Effects with your psychiatric medication? Yes No

Medication:	Dosage / Frequency:	Medication:	Dosage / Frequency:

Medical Medication

Medication:	Dosage / Frequency:	Medication:	Dosage / Frequency

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Current Concerns:

Please rate your current level of distress, from 1-10, (1=minimal to 10=extreme):

Please indicate how long you've been feeling this way:

Have you ever felt this way before? Yes No

If so, when and how severe?

What has been done so far to address these concerns?

Specify which areas of your life are affected by this problem:

Physical Home Family Relationships Work/School Financial

Legal Spiritual Other:

Significant Life Events:

Please indicate if any of the following stressors have occurred within the past 3 years:

Death of Child
Death of Spouse, Partner, Family
Death of Close Friend
Serious Problem with Child
Health Problem in Family Member
Became Disabled
Severe Illness
Personal Injury
Miscarriage or Abortion
Infertility
Relationship Conflict
Separation or Divorce
Custody Dispute
Legal Problems
Discrimination
Financial Stress
Job Loss
Retirement

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Current Relationships:

Whom are you closest to?

Are you currently in a committed romantic relationship? Yes No

If YES, with whom and for how long?

Quality of relationship: Positive Close Mixed Negative Distant

Any current romantic relationship conflicts? Yes No

Any recent breakups? Yes No

If you have children, are there any current relationship difficulties? Yes No

If you are co-parenting with an ex-partner, any areas of concern or conflict? Yes No

Any other current relationships that are of concern to you? Yes No

Other comments (optional):

Medical Status:

How would you describe your overall health?

Poor Below Average Average Above Average Excellent

Has your life changed because of your health? Yes No

Are you currently undergoing medical treatment? Yes No

If yes, please describe:

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Please indicate personal concerns with any of the following:

- [ ] Allergies
- [ ] Appetite Changes
- [ ] Arthritis
- [ ] Asthma
- [ ] Back or Spinal Injury
- [ ] Breathing Difficulties
- [ ] Cancer
- [ ] Cardiac Function
- [ ] Chest Pains
- [ ] Chronic Fatigue Syndrome
- [ ] Chronic Pain
- [ ] Decreased Energy
- [ ] Dental Problems
- [ ] Diabetes
- [ ] Dizziness
- [ ] Dry Mouth
- [ ] Eating Difficulties
- [ ] Epilepsy
- [ ] Fainting Spells
- [ ] Fibromyalgia
- [ ] Gastrointestinal Issues
- [ ] Gynecological
- [ ] Head Injury
- [ ] Hearing Problems
- [ ] Hepatitis
- [ ] HIV
- [ ] Hormones
- [ ] Hypertension
- [ ] Libido
- [ ] Limited Mobility
- [ ] Memory Problems
- [ ] Menstrual Problems
- [ ] Mental Focus
- [ ] Migraine Headaches
- [ ] Multiple Sclerosis
- [ ] Muscle Cramps
- [ ] Nightmares
- [ ] Numbness
- [ ] Pregnancy
- [ ] Reproductive Problems
- [ ] Seizures
- [ ] Sexual Problems
- [ ] Skin Disorder
- [ ] Sleep Problems
- [ ] Stroke
- [ ] Surgeries
- [ ] Terminal Illness
- [ ] TMJ Dysfunction
- [ ] Thyroid Problems
- [ ] Vision Problems
- [ ] Weight Concerns

- [ ] Other:

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Current Status:

Are you currently attending school? ◯ Yes ◯ No

Area of study: _____

Level of education completed: _____

Are you currently working? ◯ Yes ◯ No How long at current job? _____

Position: _____

Job satisfaction: ◯ High ◯ Medium ◯ Low

Job stress level: ◯ High ◯ Medium ◯ Low

Are you currently an active member of the Armed Forces? ◯ Yes ◯ No

Have you ever served in the military? ◯ Yes ◯ No

Were you ever in combat? ◯ Yes ◯ No

Current support network (check all that apply):

☐ Partner ☐ Family ☐ Friends ☐ Neighbors ☐ Church/Spiritual ☐ Community ☐ Other

Are you satisfied with your home and family life? ◯ Yes ◯ No

Any struggles with your current values, beliefs, religion or spirituality? ◯ Yes ◯ No

Current satisfaction with lifestyle, hobbies, activities: ◯ High ◯ Medium ◯ Low

Please list your favorite activities, interests or hobbies:

Briefly describe how you spend a typical day:

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DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Instructions: The questions below ask about things that might have bothered you. For each question, select the frequency that best describes how much (or how often) you have been bothered by each problem during the past TWO (2) WEEKS.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
	1. Little interest or pleasure in doing things?	○	○	○	○	○	
	2. Feeling down, depressed, or hopeless?	○	○	○	○	○	
	3. Feeling more irritated, grouchy, or angry than usual?	○	○	○	○	○	
	4. Sleeping less than usual, but still have a lot of energy?	○	○	○	○	○	
	5. Starting lots more projects than usual or doing more risky things than usual?	○	○	○	○	○	
	6. Feeling nervous, anxious, frightened, worried, or on edge?	○	○	○	○	○	
	7. Feeling panic or being frightened?	○	○	○	○	○	
	8. Avoiding situations that make you anxious?	○	○	○	○	○	
	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	○	○	○	○	○	
	10. Feeling that your illnesses are not being taken seriously enough?	○	○	○	○	○	
	11. Thoughts of actually hurting yourself?	○	○	○	○	○	
	12. Hearing things other people couldn't hear, such as voices even when no one was around?	○	○	○	○	○	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	○	○	○	○	○	
	14. Problems with sleep that affected your sleep quality over all?	○	○	○	○	○	
	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	○	○	○	○	○	
	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	○	○	○	○	○	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	○	○	○	○	○	
	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	○	○	○	○	○	
	19. Not knowing who you really are or what you want out of life?	○	○	○	○	○	
	20. Not feeling close to other people or enjoying your relationships with them?	○	○	○	○	○	
	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	○	○	○	○	○	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	○	○	○	○	○	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	○	○	○	○	○	

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Mental Health Treatment History:

Have you ever met with a therapist? ◯ Yes ◯ No

If yes, please complete below:

Provider Name:	Dates of Treatment:	Reason for Treatment:

Have you ever been hospitalized for a mental health condition? ◯ Yes ◯ No

If yes, please complete below:

Facility Name:	Dates of Treatment:	Reason for Treatment:

Have you previously taken psychiatric medication? Yes ◯ No ◯

If yes, please complete below:

Medication:	When taken:	Why stopped:

Please list any support groups or other types of treatment or support you have found helpful:

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Mental Health History:

Have you ever experienced any significant traumatic event, such as:

- ☐ Suicide of a Loved One
- ☐ Accidental/Unexpected Death of Loved One
- ☐ Serious Accident
- ☐ Near-Death Experience
- ☐ Medical Trauma
- ☐ Terminal/Disabling Condition
- ☐ Physical, Sexual or Emotional Abuse
- ☐ Corporal Punishment
- ☐ Foster Care
- ☐ Bullying
- ☐ Assault or Rape
- ☐ Domestic Violence
- ☐ Violent Crime
- ☐ Witnessing Violence
- ☐ Homelessness
- ☐ Natural Disasters
- ☐ Major Losses
- ☐ Other

If other, elaborate (optional):

Have you ever intentionally harmed yourself or seriously thought about doing so?	◯ Yes	◯ No
Have you suffered racial, sexual, or other forms of discrimination?	◯ Yes	◯ No
Do you have a history of alcohol or substance abuse?	◯ Yes	◯ No
Do you have a history of an eating disorder (restricting, binging, purging)?	◯ Yes	◯ No
Any history of gambling, shopping, sexual, or other behavioral addictions?	◯ Yes	◯ No
Do you have a history of unstable relationships?	◯ Yes	◯ No
Have you frequently changed jobs?	◯ Yes	◯ No
Have you ever been in trouble because of your temper or violence?	◯ Yes	◯ No
Have you ever been convicted of a misdemeanor or felony?	◯ Yes	◯ No

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Childhood Trauma History:

Adverse Childhood Experience (ACE) Questionnaire

While you were growing up, during your first 18 years of life:		Yes	No
1	Did a parent or other adult in the household **often…** Swear at you, insult you, put you down, or humiliate you? **or** Act in a way that made you afraid that you might be physically hurt?	○	○
2	Did a parent or other adult in the household **often…** Push, grab, slap, or throw something at you? **or ever** Hit you so hard that you had marks or were injured?	○	○
3	Did an adult or person at least 5 years older than you **ever…** Touch or fondle you or have you touch their body in a sexual way? **or** Try to or actually have oral, anal, or vaginal sex with you?	○	○
4	Did you **often** feel that … No one in your family loved you or thought you were important or special? **or** Your family didn't look out for, feel close to, or support each other?	○	○
5	Did you **often** feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? **or** Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	○	○
6	Were your parents **ever** separated or divorced?	○	○
7	Was your mother or stepmother: **Often** pushed, grabbed, slapped, or had something thrown at her? **or** **Sometimes or often** kicked, bitten, hit with a fist, or hit with something hard? **or** **Ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?	○	○
8	Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	○	○
9	Was a household member depressed or mentally ill or did a household member attempt suicide?	○	○
10	Did a household member go to prison?	○	○

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Childhood, Family and Relationship History:

Where were you born / raised?

Who raised you? Were you adopted? Yes No

Were there frequent family moves? Yes No

Is your mother still alive? Yes No Are you in communication with her? Yes No

Relationship growing up: Positive Close Mixed Negative Distant Other

Is your father still alive? Yes No Are you in communication with him? Yes No

Relationship growing up: Positive Close Mixed Negative Distant Other

Parents: Married Never Married Separated Divorced

How many siblings? Are you in communication with some / all of them? Yes No

Please indicate your birth order: Oldest Youngest Somewhere in the Middle

Significant Other(s) in childhood:

Indicate quality and experience of childhood home life (check all that apply):

Positive	Loving	Stable	Fun	Variable
Negative	Unstable	Chaotic	Rejecting	Lonely
Abusive	Violent	Poverty	Arrests	Deaths

Any developmental delays? Yes No Childhood medical problems? Yes No

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Please indicate your school experience:

Elementary School ◯ Positive ◯ Negative ◯ Mixed

Middle/High School ◯ Positive ◯ Negative ◯ Mixed

Did you experience any of the following at school?

☐ Attention difficulties ☐ Truancy ☐ Behavioral problems ☐ Bullying

☐ Learning difficulties ☐ Special education ☐ Suspension ☐ Social difficulties

Age at first relationship: ☐

Any difficulties related to sexual orientation or sexual identity ◯ Yes ◯ No

At what age did you leave home and why?

If currently married, how old were you at the time of marriage? ☐

How old was your spouse at the time of marriage? ☐

If previously married, what age were you at the time of that marriage? ☐

When did marriage end? ☐

Briefly describe why marriage ended:

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Family Mental Health:

Please indicate if any of the following mental health conditions are/were present or suspected in immediate or extended family:

Condition	Family Member(s)	Condition	Family Member(s)
☐ Alcohol Abuse		☐ Learning Difficulties	
☐ Anger Problems		☐ Legal Problems	
☐ Anxiety		☐ Memory Impairment	
☐ Attentional Difficulties		☐ Mental Retardation	
☐ Autism		☐ Narcissistic	
☐ Bipolar Disorder		☐ Obsessive-Compulsive	
☐ Borderline		☐ Post-Traumatic Stress	
☐ Conduct Problems		☐ Schizophrenia	
☐ Depression		☐ Substance Abuse	
☐ Dementia		☐ Suicide Attempts	
☐ Eating Disorder		☐ Suicide Completed	
☐ Gambling Problem		☐ Violence	
☐ Health Problems		☐ Other	

Strengths and Goals:

When did you last feel emotionally healthy?

How have you made it through difficult times before?

What do you value most about yourself?

What are you wanting to change about your life?

What will you be doing differently once your therapy goals are met?