SOUTH COUNTY
PSYCHOLOGICAL, INC.
Finding solutions and feeling better.

CLIENT INFORMATION

Today's Date: _____

Basic Information

Title: (circle one) Miss/ Master/ Ms./ Mrs./ Mr./ Dr. / Rev./ Hon.

Name_____ Email: _____
First Middle Initial Last

Name you like to be called: _____ Gender (circle one): Male Female Other

Birth date (mm/dd/yy): ____/____/____ Age: _____ Social Security Number: _____ - _____ - _____

Address: _____
Street City Zip Code

Phone: (home) _____ (cell) _____ (work) _____

Ethnicity: ____ Caucasian (White) ____ African American ____ Hispanic ____ Asian American
____ Pacific Islander ____ Native American ____ Other: _____

Financially Responsible Party (if not the client): _____
Name Relationship

Address: (if different from client): _____ Phone:_____
Street City/State Zip

Type of Insurance: _____ HMO / PPO (circle one)

ID #: _____ Group #: _____

Marriage/Family Status

Marital status: ____ Single/Never married ____ Serious Relationship ____ Married
____ Separated ____ Divorced ____ Widow/Widower

If ever married, # of marriages: _____ If widowed or divorced, when: _____

Do you have any children? ____ no ____ yes: how many? _____ ages: _____

Education/Employment

Highest education completed: _____ Career/job: _____

Employment status: ____ Full-time ____ Part-time ____ Stay-at-home caregiver
____ Under-employed ____ Unemployed ____ Student @ _____
____ Disabled: ____ temporarily OR ____ permanently

Therapy Concerns

Please state the major reasons or concerns that led you to seek therapy at this time. _____

_____

_____

I am seeking: ____ individual therapy, for: ____ myself ____ my child
____ couple's therapy ____ family therapy ____ group therapy

Do you feel suicidal (think you will kill yourself) today? _____ no ____ yes

Psychiatric Medications

Are you currently taking medication for mental health problems/reasons? ____ no ____ yes

If so, what are you taking? _____

Who prescribes those for you? _____

If you have taken other mental health medications (i.e., psychotropic meds) in the past, please list them here: _____

Therapy/Mental Health History

Have you ever had therapy/counseling/psychotherapy before? ____ no ____ yes

If so, your experience was: ____ positive ____negative ____ neutral ____ limited

Have you ever been hospitalized for mental health reasons? ____ no ____ yes

If so, how many times? _____ What was your longest stay? _____

Facility: _____ Dates: _____ Reason: _____
Facility: _____ Dates: _____ Reason: _____
Facility: _____ Dates: _____ Reason: _____

Have you ever attempted suicide? _____ no _____ yes If so, how many times? _____

If yes, please describe: _____

Have you ever purposefully harmed yourself, including cut on yourself, burned yourself, stuck sharp objects into yourself, scratched yourself with the intent to bleed, or used any other means of intentionally hurting yourself? ____ no ____ yes

Have you ever experienced any of the following when not using drugs or alcohol (check all that apply):

____ 2 or more weeks of depression, irritability, loss of interest, and unable to make decisions
____ anxiety about everything and nothing, most of the time
____ frequent nightmares after a horrible or life threatening experience
____ no sleep for 3 or more consecutive nights with too much energy and very fast thoughts
____ panic attacks (need to get out/feel closed in, shortness of breath, sweating, rapid heartbeat)
____ felt driven or compelled to do something a certain number of times every time before you can move on to other tasks in your normal routine
____ hearing voices other couldn't hear or seeing things others couldn't see
____ received special messages from the radio or television that were meant just for you
____ felt like everyone is out to get you

Physical Health Status

Please note any current medical problems: _____

_____

Have you ever had a concussion? ____ no ____ yes If so, how many? _____
Have you ever been in a coma? ____ no ____ yes If so, how long did it last? _____
Have you ever had seizures? ____ no ____ yes If so, when was the last time? _____
Do you drink alcohol? ____ no ____ yes If so, # per week? _____
Do you use other substances, drugs, or abuse prescription medications? ____ no ____ yes
If so, which ones: _____
Have you used drugs in the past? ____ no ____ yes Which ones? _____

Legal Status

Have you ever been arrested? ____ no _____ yes
Have you ever assaulted someone? ____ no ____ yes If so, who? _____
Have you ever been convicted of a crime? ____ no ____ yes
If so, what were you convicted of? _____
Have you ever been in trouble for a sexual crime, even if you were not convicted? ____ no ____ yes
Do you have any current legal problems/cases (including child custody) pending? ____ no ____ yes
If so, please describe: _____

Have you ever been assaulted or been the victim of a violent crime, even if it was never reported to authorities? ____ no ____ yes

Social/Occupational Functioning

What is your living situation? ____ live alone ____ live with others: _____
How many close friends do you have? ____ none ____ one ____ a few ____ many
Are you able to talk to your family or friends about the reasons you come to therapy? ____no ____yes
How would you describe your relationships with your family? _____

_____

How do you feel about work or school?

____pleased ____mostly satisfied ____mixed ____mostly dissatisfied ____unhappy

Please list your hobbies or recreational activities: _____

Emergency Contacts

Whom (family, friends, or others) may we contact in case of an emergency?

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Is there anyone else you would like for South County Psychological, Inc. to be able to leave messages with about your appointment days, times, or cancellations (i.e., spouse, children, or roommate)?

____ no _____ yes If yes, provide the name and indicate your relationship to that person:

Name: _____

Relationship to you: _____

Other

Is there anything else you would like Dr. Novak to know before meeting with you?

_____

_____

_____

Signature Confirmation

I have completed this form honestly and accurately, including disclosing all requested information and providing any other information that may be relevant or necessary to my successful treatment. I understand that withholding or misrepresenting information could alter the effectiveness of my treatment from South County Psychological, Inc.

_____ _____

Signature Date