PATIENT INFORMATION PROFILE

PATIENT INFORMATION **Date** _____

Last Name: _____ First: _____ Middle Initial:_____

Address: _____ City: _____ ST: _____ ZIP:_____

Telephone: Home (____) ____-_____ Work (____) ____-_____ Cell (____) ____-_____

Social Security #: _____ Birthdate: ____/___/____ M:____ F:_____

INSURANCE COMPANY INFORMATION - PRIMARY INSURANCE POLICY HOLDER INFORMATION

Last Name: _____ First: _____ Middle Initial: _____

Address: _____ City: _____ ST: _____ ZIP: _____

Telephone: Home (____) _____-_____ Work (___)____-_____

Social Security #: _____ Birthdate: ____/___/____ M:____ F:_____

Under Employer's Health Plan? □ Yes □ No

Status **(Champus claims only)** □ Active duty □ Retired □ Deceased □ Other

Relationship to insured: □ Self □ Spouse □ Child □ Other

Employer Name: _____Insurance Co. Name: _____

Address:_____ City: _____ST:____ ZIP: _____

ID Number: _____Policy Number:_____ Group Number: _____

INSURANCE COMPANY INFORMATION – SECONDARY INSURANCE POLICY HOLDER INFORMATION

Last Name: _____ First: _____ Middle Initial: _____

Address: _____ City: _____ ST: _____ ZIP: _____

Telephone: Home (____) _____-_____ Work (____) _____-_____

Social Security #: _____ Birthdate: ____/___/____ M:____ F: _____

Under Employer's Health Plan? □ Yes □ No

Status **(Champus claims only)** □ Active duty □ Retired □ Deceased □ Other

Relationship to insured: □ Self □ Spouse □ Child □ Other

Employer Name: _____Insurance Co. Name: _____

Address:_____ City: _____ST:_____ ZIP: _____

ID Number: _____Policy Number:_____ Group Number: _____

If responsible party is other than insured, please list below:

Last Name: _____ First: _____ Middle Initial: _____

Address: _____ City: _____ ST: _____ ZIP: _____

Telephone: Home (____) _____-_____ Work (____) _____-_____

SSN: _____

Name and phone number of person to contact in case of an emergency and relationship:

_____

List all family members who now reside within the patient's residence (including yourself if you are the patient):

Name _____ Birthdate _____ Relationship _____

Name _____ Birthdate _____ Relationship _____

Name _____ Birthdate _____ Relationship _____

Name _____ Birthdate _____ Relationship _____

Name _____ Birthdate _____ Relationship _____

Name _____ Birthdate _____ Relationship _____

Name _____ Birthdate _____ Relationship _____

Name _____ Birthdate _____ Relationship _____

Family Physician:_____ Phone #: _____

Educational Background:	_____ High School	□ Yes	□ No	_____ Years
	_____ College	□ Yes	□ No	_____ Years
	_____ Post Grad.	□ Yes	□ No	_____ Years

Referral Source: _____

Please answer the following questions as to whether there is a history of any of the following in the patient or immediate family.

Yes ____ No ____ 1. Alcoholism, drinking problem or drug abuse

Yes ____ No ____ 2. Attempted suicide

Yes ____ No ____ 3. Epilepsy or Seizure disorder

Yes ____ No ____ 4. Heart or cardiovascular problem

Yes ____ No ____ 5. Neurological conditions

Yes ____ No ____ 6. Learning problems

Yes ____ No ____ 7. Physical or sexual abuse

Yes ____ No ____ 8. Change in eating or sleeping habits

Yes ____ No ____ 9. Congenital disease or Mental Retardation

Have there been any psychiatric or emotional problems in your immediate or extended family?
If yes, please specify

_____
_____

Why are you seeking counseling/consultation?

_____
_____
_____

Please summarize any major medical/surgical illnesses you have experienced:

_____
_____
_____
_____

Yes ____ No ____ Are you/this patient currently taking any medications? If yes, please give
Prescription and dosage:_____
Prescription and dosage:_____
Prescription and dosage:_____
Prescription and dosage:_____
Prescription and dosage:_____

Yes ____ No ____ Have you had prior counseling? If yes, the year and name of provider:

Provider: _____

Reason for treatment: _____

Yes ____ No ____ Legal History: Have you ever been arrested? If yes, please specify reason and date of charge: _____

Yes ____ No ____ Are you presently on probation/parole? If yes, name of your probation officer: _____

Religious Preference: _____

Yes _____ No ____ Do you wish to have your clergy notified and involved in your treatment?
If yes, list name, address, and telephone number:

_____
_____

Patient Signature: _____**Date:**_____

BIOPSYCHOSOCIAL HISTORY

PRESENTING PROBLEMS

Presenting problems:	Duration (months):	Additional information:

CURRENT SYMPTOM CHECKLIST (Rate the severity of each symptom present)

None = This symptom not present at this time • Mild = Impacts quality of life, but no significant impairment of day-to-day functioning
Moderate = Significant impact on quality of life and/or day-to-day functioning • Severe = Profound impact on quality of life and/or day-to-day functioning

	None	Mild	Moderate	Severe
depressed mood	☐	☐	☐	☐
appetite disturbance	☐	☐	☐	☐
sleep disturbance	☐	☐	☐	☐
elimination disturbance	☐	☐	☐	☐
fatigue/low energy	☐	☐	☐	☐
psychomotor retardation	☐	☐	☐	☐
poor concentration	☐	☐	☐	☐
poor grooming	☐	☐	☐	☐
mood swings	☐	☐	☐	☐
agitation	☐	☐	☐	☐
emotionality	☐	☐	☐	☐
irritability	☐	☐	☐	☐
generalized anxiety	☐	☐	☐	☐
panic attacks	☐	☐	☐	☐
phobias	☐	☐	☐	☐
obsessions/compulsions	☐	☐	☐	☐

	None	Mild	Moderate	Severe
bingeing/purging	☐	☐	☐	☐
laxative/diuretic abuse	☐	☐	☐	☐
anorexia	☐	☐	☐	☐
paranoid ideation	☐	☐	☐	☐
circumstantial symptoms	☐	☐	☐	☐
loose associations	☐	☐	☐	☐
delusions	☐	☐	☐	☐
hallucinations	☐	☐	☐	☐
aggressive behaviors	☐	☐	☐	☐
conduct problems	☐	☐	☐	☐
oppositional behavior	☐	☐	☐	☐
sexual dysfunction	☐	☐	☐	☐
grief	☐	☐	☐	☐
hopelessness	☐	☐	☐	☐
social isolation	☐	☐	☐	☐
worthlessness	☐	☐	☐	☐

	None	Mild	Moderate	Severe
guilt	☐	☐	☐	☐
elevated mood	☐	☐	☐	☐
hyperactivity	☐	☐	☐	☐
dissociative states	☐	☐	☐	☐
somatic complaints	☐	☐	☐	☐
self-mutilation	☐	☐	☐	☐
significant weight gain/loss	☐	☐	☐	☐
concomitant medical condition	☐	☐	☐	☐
emotional trauma victim	☐	☐	☐	☐
physical trauma victim	☐	☐	☐	☐
sexual trauma victim	☐	☐	☐	☐
emotional trauma perpetrator	☐	☐	☐	☐
physical trauma perpetrator	☐	☐	☐	☐
sexual trauma perpetrator	☐	☐	☐	☐
substance use/abuse	☐	☐	☐	☐
other (specify)	☐	☐	☐	☐

EMOTIONAL/PSYCHIATRIC HISTORY

☐ ☐ **Prior outpatient psychotherapy?**
No Yes If yes, on _____ occasions. Longest treatment by _____ (Provider Name) for _____ sessions from ____/____ (Month/Year) to ____/____ (Month/Year)

Prior provider name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?

☐ ☐ **Has any family member had outpatient psychotherapy? If yes, who/why (list all):** _____
No Yes

☐ ☐ **Prior inpatient treatment for a psychiatric, emotional, or substance use disorder?**
No Yes If yes, on _____ occasions. Longest treatment at _____ (Name of facility) from ____/____ (Month/Year) to ____/____ (Month/Year)

Inpatient facility name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?

☐ ☐ **Has any family member had inpatient treatment for a psychiatric, emotional, or substance use disorder? If yes, who/why (list all):**
No Yes _____

☐ ☐ **Prior or current psychotropic medication usage? If yes:**

No Yes Medication	Dosage	Frequency	Start date	End date	Physician	Side effects	Beneficial?

☐ ☐ **Has any family member used psychotropic medications? If yes, who/what/why (list all):** _____
No Yes _____

FAMILY HISTORY

FAMILY OF ORIGIN

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
mother	☐	☐	☐
father	☐	☐	☐
stepmother	☐	☐	☐
stepfather	☐	☐	☐
brother(s)	☐	☐	☐
sister(s)	☐	☐	☐
other (specify)	☐	☐	☐

_____

Parents' current marital status:

- ☐ married to each other
- ☐ separated for _____ years
- ☐ divorced for _____ years
- ☐ mother remarried _____ times
- ☐ father remarried _____ times
- ☐ mother involved with someone
- ☐ father involved with someone
- ☐ mother deceased for _____ years
  age of patient at mother's death _____
- ☐ father deceased for _____ years
  age of patient at father's death _____

Describe parents:

Father	Mother
full name _____	full name _____
occupation _____	occupation _____
education level _____	education level _____
general health _____	general health _____

Describe childhood family experience:

- ☐ outstanding home environment
- ☐ normal home environment
- ☐ chaotic home environment
- ☐ witnessed physical/verbal/sexual abuse toward others
- ☐ experienced physical/verbal/sexual abuse from others

Age of emancipation from home: _____ **Circumstances:** _____

_____

_____

Special circumstances in childhood: _____

_____

_____

_____

IMMEDIATE FAMILY

Marital status:

- ☐ single, never married
- ☐ engaged _____ months
- ☐ married for _____ years
- ☐ divorced for _____ years
- ☐ separated for _____ years
- ☐ divorce in process _____ months
- ☐ live-in for _____ years
- ☐ _____ prior marriages (self)
- ☐ _____ prior marriages (partner)

Intimate relationship:

- ☐ never been in serious relationship
- ☐ not currently in relationship
- ☐ currently in a serious relationship

Relationship satisfaction:

- ☐ very satisfied with relationship
- ☐ satisfied with relationship
- ☐ somewhat satisfied with relationship
- ☐ somewhat dissatisfied with relationship
- ☐ dissatisfied with relationship
- ☐ very dissatisfied with relationship

List all persons currently living in patient's household:

Name	Age	Sex	Relationship to patient

List children not living in same household as patient:

Frequency of visitation of above: _____

Describe any past or current significant issues in intimate relationships _____

_____

_____

_____

_____

Describe any past or current significant issues in other immediate family relationships: _____

_____

_____

_____

_____

MEDICAL HISTORY (check all that apply for patient)

Describe current physical health: ☐ Good ☐ Fair ☐ Poor

List name of primary care physician:
Name_____ Phone number_____

List name of psychiatrist (if any):
Name_____ Phone number_____

List any medications currently being taken (give dosage & reason):

List any known allergies: _____

List any abnormal lab test results:
Date _____ Result _____
Date _____ Result _____

Is there a history of any of the following in the family:

- ☐ tuberculosis
- ☐ birth defects
- ☐ emotional problems
- ☐ behavior problems
- ☐ thyroid problems
- ☐ cancer
- ☐ mental retardation
- ☐ heart disease
- ☐ high blood pressure
- ☐ alcoholism
- ☐ drug abuse
- ☐ diabetes
- ☐ Alzheimer's disease/dementia
- ☐ stroke
- ☐ other chronic or serious health problems_____

Describe any serious hospitalizations or accidents:
Date _____ Age _____ Reason _____
Date _____ Age _____ Reason _____
Date _____ Age _____ Reason _____

SUBSTANCE USE HISTORY (check all that apply for patient)

Family alcohol/drug abuse history:

- ☐ father
- ☐ mother
- ☐ grandparent(s)
- ☐ sibling(s)
- ☐ other _____
- ☐ stepparent/live-in
- ☐ uncle(s)/aunt(s)
- ☐ spouse/significant other
- ☐ children

Substance use status:

- ☐ no history of abuse
- ☐ active abuse
- ☐ early full remission
- ☐ early partial remission
- ☐ sustained full remission
- ☐ sustained partial remission

Substances used: (complete all that apply)

	First use age	Last use age	Current Use? (Yes/No)	Current frequency	Current amount
☐ alcohol					
☐ amphetamines/"speed"					
☐ barbiturates/"downers"					
☐ caffeine					
☐ cocaine					
☐ crack cocaine					
☐ hallucinogens (e.g., LSD)					
☐ inhalants (e.g., glue, gasoline)					
☐ marijuana or hashish					
☐ nicotine/cigarettes					
☐ PCP					
☐ prescription_____					
☐ other_____					

Treatment history:

- ☐ outpatient (age[s]_____)
- ☐ inpatient (age[s]_____)
- ☐ 12-step program (age[s]_____)
- ☐ stopped on own (age[s]_____)
- ☐ other (age[s]_____) describe:_____

Consequences of substance use (check all that apply):

- ☐ hangovers
- ☐ seizures
- ☐ blackouts
- ☐ overdose
- ☐ withdrawal symptoms
- ☐ medical complications
- ☐ tolerance changes
- ☐ loss of control amount used
- ☐ sleep disturbance
- ☐ assaults
- ☐ suicidal impulse
- ☐ relationship conflicts
- ☐ binges
- ☐ job loss
- ☐ arrests
- ☐ other: _____

DEVELOPMENTAL HISTORY (check all that apply for a child/adolescent patient)

Problems during mother's pregnancy:

- ☐ none
- ☐ high blood pressure
- ☐ kidney infection
- ☐ German measles
- ☐ emotional stress
- ☐ bleeding
- ☐ alcohol use
- ☐ drug use
- ☐ cigarette use
- ☐ other _____

Birth:

- ☐ normal delivery
- ☐ difficult delivery
- ☐ cesarean delivery
- ☐ complications_____

birth weight _____ lbs _____ oz.

Infancy:

- ☐ feeding problems
- ☐ sleep problems
- ☐ toilet training problems

Childhood health:

- ☐ chickenpox (age _____)
- ☐ German measles (age _____)
- ☐ red measles (age _____)
- ☐ rheumatic fever (age _____)
- ☐ whooping cough (age _____)
- ☐ scarlet fever (age _____)
- ☐ autism
- ☐ ear infections
- ☐ allergies to _____
- ☐ significant injuries_____
- ☐ chronic, serious health problems _____
- ☐ lead poisoning (age _____)
- ☐ mumps (age _____)
- ☐ diphtheria (age _____)
- ☐ poliomyelitis (age _____)
- ☐ pneumonia (age _____)
- ☐ tuberculosis (age _____)
- ☐ mental retardation
- ☐ asthma

DEVELOPMENTAL HISTORY

Delayed developmental milestones (check only those milestones that did not occur at expected age):

- ☐ sitting
- ☐ rolling over
- ☐ standing
- ☐ walking
- ☐ feeding self
- ☐ speaking words
- ☐ speaking sentences
- ☐ controlling bladder
- ☐ controlling bowels
- ☐ sleeping alone
- ☐ dressing self
- ☐ engaging peers
- ☐ tolerating separation
- ☐ playing cooperatively
- ☐ riding tricycle
- ☐ riding bicycle
- ☐ other _____

Emotional / behavior problems (check all that apply):

- ☐ drug abuse
- ☐ alcohol abuse
- ☐ chronic lying
- ☐ stealing
- ☐ violent temper
- ☐ fire-setting
- ☐ hyperactive
- ☐ animal cruelty
- ☐ assaults others
- ☐ disobedient
- ☐ repeats words of others
- ☐ not trustworthy
- ☐ hostile/angry mood
- ☐ indecisive
- ☐ immature
- ☐ bizarre behavior
- ☐ self-injurious threats
- ☐ frequently tearful
- ☐ frequent daydreams
- ☐ lack of attachment
- ☐ distrustful
- ☐ extreme worrier
- ☐ self-injurious acts
- ☐ impulsive
- ☐ easily distracted
- ☐ poor concentration
- ☐ often sad
- ☐ breaks things
- ☐ other _____

Social interaction (check all that apply):

- ☐ normal social interaction
- ☐ isolates self
- ☐ very shy
- ☐ alienates self
- ☐ inappropriate sex play
- ☐ dominates others
- ☐ associates with acting-out peers
- ☐ other _____

Intellectual / academic functioning (check all that apply):

- ☐ normal intelligence
- ☐ high intelligence
- ☐ learning problems
- ☐ authority conflicts
- ☐ attention problems
- ☐ underachieving
- ☐ mild retardation
- ☐ moderate retardation
- ☐ severe retardation

Current or highest education level _____

Describe any other developmental problems or issues: _____

_____

SOCIO-ECONOMIC HISTORY (check all that apply for patient)

Living situation:

- ☐ housing adequate
- ☐ homeless
- ☐ housing overcrowded
- ☐ dependent on others for housing
- ☐ housing dangerous/deteriorating
- ☐ living companions dysfunctional

Employment:

- ☐ employed and satisfied
- ☐ employed but dissatisfied
- ☐ unemployed
- ☐ coworker conflicts
- ☐ supervisor conflicts
- ☐ unstable work history
- ☐ disabled: _____

Financial situation:

- ☐ no current financial problems
- ☐ large indebtedness
- ☐ poverty or below-poverty income
- ☐ impulsive spending
- ☐ relationship conflicts over finances

Social support system:

- ☐ supportive network
- ☐ few friends
- ☐ substance-use–based friends
- ☐ no friends
- ☐ distant from family of origin

Military history:

- ☐ never in military
- ☐ served in military—no incident
- ☐ served in military with incident

_____

Legal history:

- ☐ no legal problems
- ☐ now on parole/probation
- ☐ arrest(s) not substance-related
- ☐ arrest(s) substance-related
- ☐ court ordered this treatment
- ☐ jail/prison ____ time(s)

total time served: _____

describe last legal difficulty ___

_____

Sexual history:

- ☐ heterosexual orientation
- ☐ homosexual orientation
- ☐ bisexual orientation
- ☐ currently sexually active
- ☐ currently sexually satisfied
- ☐ currently sexually dissatisfied
- ☐ age of first sex experience _____
- ☐ age first pregnancy/fatherhood ___
- ☐ history of promiscuity age __ to __
- ☐ history of unsafe sex age ___ to ___

Additional information: _____

Cultural/spiritual/recreational history:

cultural identity (e.g., ethnicity, religion): _____

_____

describe any cultural issues that contribute to current problem: _____

_____

currently active in community/recreational activities? Yes ☐ No ☐

formerly active in community/recreational activities? Yes ☐ No ☐

currently engage in hobbies? Yes ☐ No ☐

currently participate in spiritual activities? Yes ☐ No ☐

if answered "yes" to any of above, describe: _____

_____

_____

SOURCES OF DATA PROVIDED ABOVE: ☐ Patient self-report for all ☐ A variety of sources (if so, check appropriate sources below):

Presenting Problems/Symptoms

- ☐ patient self-report
- ☐ patient's parent/guardian
- ☐ other (specify)_____

Emotional/Psychiatric History

- ☐ patient self-report
- ☐ patient's parent/guardian
- ☐ other (specify)_____

Family History

- ☐ patient self-report
- ☐ patient's parent/guardian
- ☐ other (specify)_____

Medical/Substance Use History

- ☐ patient self-report
- ☐ patient's parent/guardian
- ☐ other (specify)_____

Developmental History

- ☐ patient self-report
- ☐ patient's parent/guardian
- ☐ other (specify)_____

Socioeconomic History

- ☐ patient self-report
- ☐ patient's parent/guardian
- ☐ other (specify)_____