INTERACTIONAL SERVICES

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Adult Psychological Evaluation and Psychotherapy

Patient Information Form

DEMOGRAPHIC INFORMATION

Name: _____ Age: _____ Date of birth: _____

Ethnicity: _____ Gender Identity: _____

Relationship Status: _____ Sexual Orientation: _____

Religious or Spiritual Affiliation:_____

Date: _____ How were you referred? _____

Reason for Referral and Presenting Concerns (What brings you to Interactional Services?):

_____

_____

_____

_____

MEDICAL & PSYCHIATRIC HISTORY

Please list any medical or psychiatric illnesses you currently have or have had in the past:

	Illness	Currently	If no, when in past
1.		YES NO	
2.		YES NO	
3.		YES NO	
4.		YES NO	
5.		YES NO	
6.		YES NO	
7.		YES NO	
8.		YES NO	

Current / Previous Medications	Dosage	Times per day	Date started

Please list any previous hospitalizations/operations:

	Condition	Date	Hospital
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Have you ever had?

an MRI scan of the brain?	YES NO	**If yes, when?**
a CAT scan of the brain?	YES NO	**If yes, when?**
an EEG test?	YES NO	**If yes, when?**

DEVELOPMENTAL HISTORY

Are you aware of any of the following? (check all that apply)

____ Problems during prenatal development?

____ Exposure to drugs or alcohol prenatally?

Developmental delay in: ____Speech/language
____Motor Skills
____Physical Development
____Social Development

____ Serious childhood illness or injury?

Have you ever had?

Vision Problems?	NO YES	**Glasses:** NO YES **Glaucoma:** NO YES Right eye Left eye **Blurring:** NO YES Right eye Left eye **Double vision:** NO YES
Hearing Problems?	NO YES	**Hearing aids:** NO YES Right ear Left ear **Ringing:** NO YES Right ear Left ear **Buzzing:** NO YES Right ear Left ear
Stroke?	NO YES	
Head injury?	NO YES	
Episodes where you passed out, blacked out, or fainted (lost consciousness)?	NO YES	Describe:
Other neurological problems?	NO YES	
High Blood Pressure?	NO YES	
High Cholesterol?	NO YES	
Diabetes?	NO YES	Describe:
Seizures?	NO YES	**What type:** Grand Mal Petite Mal Absence **How often:**_____
Headaches?	NO YES	**What type:** Tension Migraine Sinus **How often:**_____
Tremors?	NO YES	Describe:
Balance problems?	NO YES	Describe:
Urinary Incontinence?	NO YES	Describe:
Weakness in any part of your body?	NO YES	Describe:
Numbness in any part of your body?	NO YES	Describe:
Any motor vehicle accidents?	NO YES	**How many accidents?**_____ **Were you seriously injured?** NO YES **Were you hit on the head?** NO YES **Were you knocked out?** NO YES **For how long?** __ minutes hours days

Are you involved in any lawsuits?	NO YES	If yes, please explain:
Have you ever been convicted of a crime?	NO YES	If yes, please explain:

Do you smoke cigarettes currently?	NO YES	_____ **Packs per day**
Have you smoked cigarettes in the past?	NO YES	_____ **Packs per day,** for _____ years **Year stopped:** _____
Do you drink alcohol currently?	NO YES	_____ **Drinks per week** (1 drink = 1 beer, or 1 glass of wine, or 1 mixed drink) **Type of Alcohol:** _____
Have you used alcohol in the past?	NO YES	_____ **Drinks per day,** for _____ years **Year stopped:** _____ **Type of Alcohol:** _____
Do you use recreational drugs currently?	NO YES	**Describe:**
Have you used recreational drugs in the past?	NO YES	
Have you ever overused prescription medication to relieve pain or distress?	NO YES	

Have you ever been to counseling or psychotherapy before? ___ NO ___ YES

If yes, what was your experience like? _____

_____

_____

Have you ever had a psychological evaluation? ___ NO ___ YES

If yes, what was your experience like? _____

_____

_____

Have you recently experienced:

Recent changes in weight or appetite?	NO YES	**Appetite change:** MILD MODERATE SEVERE **Weight change:** _____Pounds Loss or Gain
Describe your sleep pattern:	Recently:	
Felt depressed recently?	NO YES	MILD MODERATE SEVERE
Experienced anxiety recently?	NO YES	MILD MODERATE SEVERE
Heard or seen things that others have not?	NO YES	If yes, please explain:
Have you recently thought about suicide?	NO YES	If yes, please explain:
Have you ever thought about or attempted suicide?	NO YES	If yes, please explain:
Have changes in the way you get along with your family members?	NO YES	MILD MODERATE SEVERE **Please describe:**
Have any changes in your personality?	NO YES	MILD MODERATE SEVERE **Please describe:**
Have less interest in social activities or time with friends?	NO YES	MILD MODERATE SEVERE
Feel more irritable?	NO YES	MILD MODERATE SEVERE

Please indicate any **family** history of:

Condition		**Family member**
Strokes	YES NO	
Seizures	YES NO	
Alzheimer's disease or other type of dementia	YES NO	
High Blood Pressure	YES NO	

Heart Disease	YES NO	
Depression	YES NO	
Anxiety	YES NO	
Other Mental Health problems	YES NO	
Other serious medical or mental health conditions		

Do You:

Have problems with memory?	NO YES	MILD MODERATE SEVERE **Memory loss:** **Worsened gradually** YES NO **Began suddenly** YES NO **Occurs off & on** YES NO **Is worse at end of the day** YES NO
Have problems understanding what you read?	NO YES	MILD MODERATE SEVERE
Have problems understanding what other people say?	NO YES	MILD MODERATE SEVERE **Is this because of poor hearing?** NO YES SOME
Have changes in your handwriting?	NO YES	MILD MODERATE SEVERE
Have problems concentrating or paying attention?	NO YES	MILD MODERATE SEVERE
Have problems finding the "right" word when talking?	NO YES	MILD MODERATE SEVERE
Have problems remembering names?	NO YES	MILD MODERATE SEVERE
Have problems with math or with handling money?	NO YES NO YES	MILD MODERATE SEVERE MILD MODERATE SEVERE

Do you need assistance with any of the following activities?

Activity	Never	Sometimes	Always
Cleaning house			
Preparing meals			
Paying bills			
Keeping track of medication			
Transportation (Driving)			
Bathing			
Dressing			
Walking			
Getting up and down			

SOCIAL INFORMATION

Marital Status: Single

Divorced Widowed

Married Co-habitating How is the health of your partner? GOOD FAIR POOR

Of Marriages ___

Names of People living with you	Relationship to you

Names of other family not living with you	Relationship	Place of residence

PSYCHOSOCIAL HISTORY

How would you describe your childhood?	**Circle all that apply:** HAPPY NORMAL DIFFICULT TROUBLED LONELY IDYLLIC CALM SAD FEARFUL DEPRIVED OTHER (PLEASE DESCRIBE):	
Have you ever experienced any traumatic events in your life?	NO YES	**If yes, circle all that apply:** DEATH OF PARENT OTHER DEATHS VERBAL ABUSE PHYSICAL ABUSE SEXUAL ABUSE FAMILY VIOLENCE CRIME VICTIM NEGLECT OTHER (PLEASE DESCRIBE):
List any other significant events in your childhood or later life:		

SCHOOL INFORMATION

Last school grade completed?_____ **Degree(s) Received**_____

Name of last school attended:_____

How would you describe your grades? EXCELLENT ABOVE AVERAGE AVERAGE POOR FAILING
UNDERACHIEVER OTHER:_____

If you left school before graduation, what was the reason?_____

List any special training or education:_____

Did you have any learning problems in school? YES NO

If yes, circle which were problem areas: READING WRITING MATH BEHAVIORAL
PAYING ATTENTION OTHER:_____

If yes, did you receive any special help? YES NO

If yes, did you or do you have trouble paying attention while taking notes? YES NO

If yes, is it hard for you to study and retain information? YES NO

If yes, did you complete tests in the time provided? YES NO

Did you procrastinate? YES NO Did this lead to missed work? YES NO

Did you select classes to maximize grades? YES NO

WORK HISTORY

Primary Occupation:_____

Are you retired? NO YES If yes, since when:_____

Type of retirement: VOLUNTARY MEDICAL

Current activities: _____

Are you disabled? NO YES If yes, since when:_____

What caused the disability?_____

Do you receive Social Security benefits? YES NO

Do you receive Private Disability benefits? YES NO

Please list your last few jobs:

Position	Employer	Approximate dates of employment

Have you served in the military? YES NO

What branch? _____How long? _____ Active: _____ Reserves: _____

Primary job responsibilities?_____

Are there any other areas of concern? (Use back of sheet if needed)