Client Information

TODAY'S DATE: _____

NAME: _____

BIRTHDATE: _____

ETHNICITY, CULTURAL, AND RELIGIOUS BACKGROUND:

_____

CELL PHONE NUMBER: _____
Is it OK to leave a message? Yes No

HOME PHONE NUMBER: _____
Is it OK to leave a message? Yes No

WORK PHONE NUMBER_____
Is it OK to leave a message? Yes No

EMAIL: _____

ADDRESS:

Street_____ Apartment # _____

City_____ Zip Code_____

MARITAL STATUS: _____

YEARS OF EDUCATION: _____

EMPLOYMENT STATUS: _____

PLACE OF WORK: _____

POSITION: _____

MILITARY HISTORY? ___ Yes ___NO BRANCH_____

COMBAT EXPERIENCE ___Yes ____NO OVERSEAS DUTY ___Yes ___NO

RESPONSIBLE PARTY: _____

ADDRESS: _____

_____

REFERRED BY: _____

Emergency Contact Information

Person to contact in the event of an emergency: _____

Relationship: _____

Home Phone: ( ) _____

Cell ( ) _____

Other ( ) _____

My signature provides permission for Dr. Matoff to contact the above individual and discuss my situation in the event of a medical and/or psychiatric emergency.

Patient Name_____

Patient Signature_____

Date_____

Background Information

Siblings: Please list your brothers and sisters and indicate if biological (B), Step (S) or half sibling (H)

Name **Age**

1.

2.

3.

4.

Please put a check mark next to any experiences you had growing up

___ Death in family ___ Serious medical or psychiatric illness ___Parent unemployment ___ Legal problems ___ Hospitalizations ____ Ongoing parental conflict ___Frequently moved

Please put a check mark next to any of these problems you had growing up?

___Physical abuse ____Sexual abuse ___ Emotional abuse ____Neglect ___Had too much responsibility ____Other

_____

Family History (including yourself) of Drugs/Alcohol _____Yes _____No

If yes, please specify who, what substance(s), how frequently, how much, and approximately for how long. Please use the back of this form if more space is required.

History of Suicide

_____ prior attempts

_____current suicide ideation (ideas without a plan)

_____current ideation and have a plan

Homicidal Thoughts or Attempts

_____ prior attempts

_____current homicidal ideation (ideas without a plan)

_____current ideation and have a plan

Previous Psychological Treatment History (check all that apply)	**___ None**	**____ Psychiatric**	**___ Substance Use**
Outpatient psychotherapy within	___ 6 months	___ 1 year	__ 2-5 years
Partial Hospitalization	___ 6 months	___ 1 year	__ 2-5 years
Residential Treatment	___ 6 months	___ 1 year	__ 2-5 years
Inpatient treatment	___ 6 months	___ 1 year	__ 2-5 years

Current Medications: Please list all current medications and the frequency in which you take them below. If you require more room, please list on the back of this paper.

1.

2.

3.

Current Health Conditions: Please describe below. If you require more room, please use the back of this paper.

Symptoms Checklist

These symptoms may or may not be a reason for seeking psychotherapy. However, they may help in treatment planning. Please check the "C" for current symptoms and/or the "P" for past symptoms.

C	P	Symptom
		Anxiousness
		Restlessness
		Feeling on edge
		Agitation or irritability
		Muscle tension
		Sense of sadness
		Dizzy
		Sweating
		Trembling or shaking
		Nausea
		Panic attacks
		Sense of dread
		Dizziness
		Fear of losing control
		Avoid certain situations
		Recurring troubling thoughts / images you cannot get out of your mind
		Repetitive behaviors such as excessive handwashing
		Changes in appetite (decrease or increase)
		Weight gain – how much?..... – how long? …….
		Weight loss – how much?..... – how long? …….
		Compulsive / binge eating
		Chewing and spitting out food
		Bulimia
		Anorexia
		Exercise addiction
		Sleep disturbances, please specify insomnia?..... or overslept?.....
		Difficulty falling asleep
		Difficulty staying asleep
		Depressed mood
		Sadness
		Empty
		Withdrawing from others
		Fatigue or loss of energy
		Body aches
		Self-injury
		Arguing with others
		Impaired memory / concentration
		Feeling guilty

C	P	**Symptom**
		Decreased sex drive
		Feeling lonely even when with other people
		Diminished interest or pleasure in activities
		Feeling of worthlessness
		Worry
		Low self esteem
		Hopelessness

Please add any other symptoms you would like me to know about below:

Self-Assessment

What do you do to manage stress in your life?

What are the three most important issues causing problems in your life now?

1.

2.

3.

What are the barriers keeping you from making effective changes in your life?

What personal strengths do you have to make changes in your life?

Describe your support system

Thank you for the time you took to fill out these forms. We will review them together to ensure that I have the best understanding of your life experiences for setting agreed upon treatment goals.