PSYCHOLOGICAL SOLUTIONS, LLC

Background Information

Personal Data of the Patient:

First Name: ____ Middle Initial: ____

Last Name: ____

Age: ____ Birth Date: ____

Social Security Number: ____

REFERRAL INFORMATION/REASON FOR APPOINTMENT

How were you referred to Psychological Solutions, LLC? ____

If a friend or colleague referred you, may we contact them to thank them for their trust in us by referring you (only a simple thank you and no other information will be given)? ____

Briefly describe the reason for this appointment: ____

Please list any treatment goals or expectations that you have: ____

PREVIOUS TREATMENT

Have you, a family member, relative or friend previously used Psychological Solutions, LLC as your treatment Provider?

☐ YES ☐ NO

If yes, under what names: ____

Have you or anyone in your family ever seen a mental health provider?

☐ YES ☐ NO

If yes, who, when, where, and why?

____

PSYCHOLOGICAL SOLUTIONS, LLC

Background Information (page 2)

What did you find Most Helpful/Useful in previous therapy?

What was least helpful/useful in previous therapy?

Have you ever been hospitalized for any psychiatric illness (e.g., Major Depression) or attended any Intensive Outpatient (IOP) or Partial Hospitalization Programs (PHP) or Long Term Inpatient Treatment Programs? ☐ YES ☐ NO

If yes, please tell us dates (if known); duration of treatment; and location as well as reason for referral to the program and any benefit you felt you received from it.

PSYCHOLOGICAL SOLUTIONS, LLC

Background Information (page 3)

COLLATERAL TREATMENT (OTHER TREATING PHYSICIANS)

Who is your Primary Care Doctor (PCP)?

Name: ________ Contact number: ________

Address and/or hospital affiliation: ________

May we contact him or her to make them aware that we are treating you and to coordinate care? ☐ YES ☐ NO

(For Women)
Who is Your OB-GYN?

Name: ________ Contact number: ________

Address and/or hospital affiliation: ________

May we contact him or her to make them aware that we are treating you and to coordinate care? ☐ YES ☐ NO

Are you presently seeing a Psychiatrist (Physician, MD OR DO)? ☐ YES ☐ NO

If yes,

Name: ________ Contact number: ________

Address and/or hospital affiliation: ________

May we contact him or her to make them aware that we are treating you and to coordinate care? ☐ YES ☐ NO

If you are not presently seeing a psychiatrist, would you like a referral to one to evaluate you for psychotropic medication to treat your problem or consult with you on psychotropic medication? ☐ YES ☐ NO

PSYCHOLOGICAL SOLUTIONS, LLC

Background Information (page 4)

Do you have any medical or physical problems (other than psychiatric)?

☐ YES ☐ NO

If yes, please describe:

Please list any medications you are taking (including psychiatric) and dosage if known. Also, list the provider who most recently prescribed this for you if known.

Do YOU or YOUR FAMILY have any significant medical problems ? ☐ YES ☐ NO

If yes, please describe:

Do you smoke tobacco? ☐ YES ☐ NO

If yes, please list the amount:

Please list the amounts and types of beverages with caffeine that you consume on a daily basis:

Do you or anyone in your family have any problems with alcohol? ☐ YES ☐ NO

If yes, please describe:

How much alcohol do you drink in a typical week?

PSYCHOLOGICAL SOLUTIONS, LLC

Background Information (page 5)

Do you or anyone in your family have any problems with Drugs? ☐ YES ☐ NO

If yes, please describe:

BASIC BACKGROUND

What kind of work do you do?

Employer: ☐ Full Time ☐ Part Time

Schedule (hours and days work)

What kind of work does your spouse/partner do?

☐ Full Time ☐ Part Time

Schedule (hours and days work)

What are the best days/times to schedule appointments for you?

What is the contact number where we can reach you, leave a message if necessary, and you can respond to us quickly (e.g., within 2 hours) should we get an appointment cancellation that fits your needs?

Is it also OK to confirm your scheduled appointments here? ☐ YES ☐ NO

If not, what number is better?

Are you married/partnered? ☐ YES ☐ NO If yes, how long?

Are you divorced? ☐ YES ☐ NO If yes, how long?

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Background Information (page 6)

Please list the names, ages and gender of your children.

Name:	Age	Gender	Step Child / Adopted

Please list your highest level of education completed (for example: high school graduate):

Please list your spouse highest level of education completed (for example: high school graduate):

Any Educational Programs started but not finished (you and/or spouse)?

What would you say are your "top" stressors in your life now?

Thank you for taking the time to complete this. Your openness and honesty will greatly assist with helping you to achieve your treatment goals.

If there is something that was not asked here that you feel we need to know, please feel free to add it here or tell it to the therapist in your first or subsequent sessions.