

**Marshall University Psychology Clinic
Information Form**

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Gender: _____

Height: _____ Weight: _____ lbs.

Contact Person (if not independent adult) _____

Why are you here? _____

Have you had previous psychological or mental health treatments? Yes No

If So Where/Reason: _____

Did previous therapy help? Yes No

Previous diagnosis? _____

Current Medications(mg, times a day): _____

Who prescribes these medications? _____

What do you want to change about yourself? _____

Goals for treatment: _____

Have you ever been physically or emotionally abused? Yes No

Do you have any health problems? _____

Current physical condition: _____

Are you getting along well socially?: Yes No

Have there been any events recently to cause the need for this visit? Yes No

If so, what? _____

Please check all that apply to you

I have Depression

I have Anxiety

I have Phobias

I have Panic Attacks

I have a Substance Use history.

I have Obsessions

I have Compulsions

I have Sexual Concerns

I have Suicidal thoughts.

I have Homicidal thoughts.

I have been hospitalized for or had outpatient for psychological/psychiatric treatment?

I have a Family history of mental disorders relating to:

Spouse's

Children

Extended family

I have been hospitalized/ had surgeries

I have had any head trauma, loss of consciousness, and/or black out?

I have Allergies

I use Caffeine

What: _____ Frequency: _____ Day Week

I smoke Cigarettes/Cigars

When Started: _____ Frequency: _____ Day Week

I drink Alcohol

What kind: _____ When started: _____

Frequency: _____ Day Week

Resulting behaviors: _____

I take Drugs

What kind: _____ When started: _____

Frequency: _____ Day Week

Resulting behaviors: _____

I take over the counter medication

What kind: _____ When started: _____

Frequency: _____ Day Week

Resulting behaviors: _____

How many hours a day do you normally sleep? _____

Quality of sleep: Restful Adequate Troubled

How is your appetite? _____

How many meals a day: _____

Any recent weight changes? _____

How do you feel physically?

Energy level: _____

Do you ever see or hear things that other people don't see or hear? Yes No

Do you have a Best Friend? Yes No

What makes you happy? _____

Do you have problems controlling your Anger? Yes No

Ever been in any physical fights? Yes No

How many? When? Over what? _____

Do you consider yourself to be a Religious person? Yes No

What do you do for fun/Hobbies? _____

Family Background

Family Medical History (If no longer living, please give age and cause of death)

Mother's health: Excellent Good Fair Poor

Comment: _____

Father's health: Excellent Good Fair Poor

Comment: _____

Maternal Grandmother: Excellent Good Fair Poor

Comment: _____

Maternal Grandfather: Excellent Good Fair Poor

Comment: _____

Paternal Grandmother: Excellent Good Fair Poor

Comment: _____

Paternal Grandfather: Excellent Good Fair Poor

Comment: _____

Sibling's health: Excellent Good Fair Poor

Comment: _____

Sibling's health: Excellent Good Fair Poor

Comment: _____

Sibling's health: Excellent Good Fair Poor

Comment: _____

Spouse's current condition/health: Excellent Good Fair Poor

Comment: _____

Children's health: Excellent Good Fair Poor

Comment: _____

Children's health: Excellent Good Fair Poor

Comment: _____

Children's health: Excellent Good Fair Poor

Comment: _____

Do you have any family members who have problems with substance abuse?

Who? _____

What Kind? _____

Marital Status/Significant Other

How long together: _____

How is your relationship with your significant other? Good Fair Poor

Occupation of Spouse : _____

Age of Spouse: _____

Children: _____

Age/Gender of children: _____

Who lives in home currently (ages/relation): _____

Who lived in the family when growing up?

Parent/s Step Parent/s Other Guardians

Siblings – How many? What Gender? _____

Other household members

Who raised you? _____

Are your parents currently: Married Divorced Widowed Deceased

Past relationship with parents, siblings, etc.:

I got along _____ with my parents/ parental figures:

Well Okay Poorly

I got along _____ with other members of my family:

Well Okay Poorly

Current relationship with:

Mother: _____

Father: _____

Siblings: (brother / sister):

Who were your favorite siblings? Why? _____

Who were your least favorite siblings? Why? _____

Who did you favor more, Mom or Dad? Why? _____

Where did you grow up? (one place, moved a lot) _____

Describe your childhood (happy, loving, etc.) _____

Did you get along with others well growing up? _____

Your Background

Check which pertains to your early childhood:

- Difficult birth
- Mother engaged in substance abuse during pregnancy
- Complications after birth
- Slow learning to walk, talk or with toilet training
- Childhood illnesses/injuries/trauma

Check what is relevant to your sexual experiences:

- I have had a same-sex sexual experience?
- I have had a bisexual experience?
- I have current concerns about sex:

Educational History

Number of years of education completed: _____

Private / Public

Disciplined or in trouble and for _____

Favorite subject? Why? _____

Least favorite subject? Why? _____

What did you think of your teachers? Why? _____

Have you...

Ever been held back a grade? Yes No

Ever diagnosed with a learning disability, behavior disorder, etc.? Yes No

Your Extracurricular Activities in School: _____

Do you feel you were popular in school? Yes No

Any trauma related to school? Yes No

College Experience

Away from home? Yes No

Successful/ Good Grades? Yes No

Degree/Major? _____

Year in College Freshman Sophomore Junior Senior Graduate

Overall experience: Excellent Good Fair Poor

Vocational History

Current job (title and responsibilities): _____

Previous jobs (titles and responsibilities): _____

Reasons for leaving: _____

Ever been fired from a job? Yes No

Relationship with boss: Excellent Good Fair Poor

Relationship with co-workers: Excellent Good Fair Poor

Military service: Yes No

Mental condition interfere with job? Yes No

Legal History

Do you have a Legal history? Yes No

Legal difficulties (past or current):
("The person denies any history of legal problems other than minor infractions.")

Ever been arrested? Yes No

Number of times? _____

What for? _____

Sentence: _____

Traffic violations/Number of times: _____

Daily Functioning

Can you drive? Yes No

Do you have a car? Yes No

Do you cook? Yes No

Can you count money? Yes No

Can you find your way home from several blocks away? Yes No

Is there anything you don't/won't do that interferes with your life? Yes No

How much TV per day? _____

Please check the following issues you'd like to address in therapy:

- I have no problem or concern bringing me here
- Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- Aggression, violence
- Alcohol use
- Anger, hostility, arguing, irritability
- Anxiety, nervousness
- Attention, concentration, distractibility
- Career concerns, goals, and choices
- Childhood issues (your own childhood)
- Codependence
- Confusion
- Compulsions
- Custody of children
- Decision making, indecision, mixed feelings, putting off decisions
- Delusions (false ideas)
- Dependence
- Depression, low mood, sadness, crying
- Divorce, separation
- Drug use—prescription medications, over-the-counter medications, street drugs
- Eating problems—overeating, undereating, appetite, vomiting (see also “Weight and diet issues”)
- Emptiness
- Failure
- Fatigue, tiredness, low energy
- Fears, phobias
- Financial or money troubles, debt, impulsive spending, low income
- Friendships
- Gambling
- Grieving, mourning, deaths, losses, divorce
- Guilt
- Headaches, other kinds of pains
- Health, illness, medical concerns, physical problems
- Housework/chores—quality, schedules, sharing duties
- Inferiority feelings
- Interpersonal conflicts
- Impulsiveness, loss of control, outbursts
- Irresponsibility
- Judgment problems, risk taking
- Legal matters, charges, suits
- Loneliness

- Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- Memory problems
- Menstrual problems, PMS, menopause
- Mood swings
- Motivation, laziness
- Nervousness, tension
- Obsessions, compulsions (thoughts or actions that repeat themselves)
- Oversensitivity to rejection
- Panic or anxiety attacks
- Parenting, child management, single parenthood
- Perfectionism
- Pessimism
- Procrastination, work inhibitions, laziness
- Relationship problems (with friends, with relatives, or at work)
- School problems (see also "Career concerns ...")
- Self-centeredness
- Self-esteem
- Self-neglect, poor self-care
- Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- Shyness, oversensitivity to criticism
- Sleep problems—too much, too little, insomnia, nightmares
- Smoking and tobacco use
- Spiritual, religious, moral, ethical issues
- Stress, relaxation, stress management, stress disorders, tension
- Suspiciousness
- Suicidal thoughts
- Temper problems, self-control, low frustration tolerance
- Thought disorganization and confusion
- Threats, violence
- Weight and diet issues
- Withdrawal, isolating
- Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition

Any other concerns or issues:

: _____

: _____

Please look back over the concerns you have checked off and choose the one that you most want help with. It is:

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.