Scott Psychological Services, PLLC

Client History and Information

Date:

Name:

Preferred Name/Nickname:

Date of Birth:

Gender:

Race/Ethnicity:

Home Address:

City:

Zipcode:

Mobile Phone Number: May we leave a message? [ ] Yes [ ] No

Email Address:

Insurance:

Insurance ID Number:

Who referred you to our office, or how did your learn about our practice?

Emergency Contact Information

In case of an emergency, who should we contact?

Name:

Relationship:

Address:

Phone Number:

Family of Origin History

Name	Relationship	Age	If deceased, age and cause of death

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Condition	Please Circle YES or NO	List family member relationship to you (father, grandmother, etc.)
Alcohol/Substance Abuse	**yes/no**	
Anxiety	**yes/no**	
Depression	**yes/no**	

Domestic Violence/Abuse	**yes/no**	
Suicide Attempts/Mental Health Hospitalization	**yes/no**	
Other diagnosed mental health condition?	**yes/no : which was---**	

Relationship History

Which best describes your marital/relationship status?

If you are in long-term relationship(s), please describe nature of that/those relationship(s):

On a scale of 1-10 (1=negative; 10=positive), how would you rate your relationship satisfaction? _____

Do you have children?

[ ] Yes [ ] No

If yes, complete the following:

Name(s)

Age(s):

Gender(s):

Other Information

Current Occupation:

On a scale of 1-10 (1=negative; 10=positive), how would you rate your work satisfaction? ______

Current Medications:

Summary of Medical History (e.g. chronic conditions, major surgeries, head injuries, or any concerns that you want to make us aware of):

Name and contact information of prescriber:

What areas of your life have been affected because of this problem?

Are you currently experiencing overwhelming sadness, grief or depression? **Yes/No**
If yes, for approximately how long? _________________________

Are you currently experiencing anxiety, panic attacks or have any phobias? **Yes/No**
If yes, when did you begin experiencing this? _________________________

What significant life changes or stressful events have you experienced recently?

Describe 2-3 aspects of your life you would like to change through counseling/therapy: