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Research Psychoanalyst (RP #41)

Please fill out this form as completely as possible. It will help facilitate our work. Information is confidential as outlined in the "New Patient Informed Consent" and the HIPAA Notice of Privacy Practices. Please print or write clearly.

NAME: _____ **M/F:** _____ **DATE :**_____

DATE and PLACE of BIRTH: _____**YOUR AGE:**_____

ADDRESS: _____

TEL: H: _____ **Cell:** _____ **Work:** _____

E-MAIL: _____

SOCIAL SECURITY NUMBER: _____

HIGHEST GRADE/DEGREE: _____ **TYPE OF DEGREE:** _____

OCCUPATION : _____

EMERGENCY CONTACT (name and phone): _____

RELATIONSHIP TO YOU: _____

REFERRAL SOURCE: _____

PRESENTING PROBLEM: (Be as specific as you can. When did it start, how does it affect you…)

Estimate the severity of above problem(s): Mild – Moderate – Severe - Very severe

CURRENT RELATIONSHIP STATUS:_____ **Live with others?:**_____

Name of partner/roommates: _____

No. of years together: _____

Present spouse/partner education: _____

Present spouse/partner occupation: _____

PAST & PRESENT MARRIAGE/S (years together, names and brief statement about the nature of the relationship/s, i.e., friendly, distant, physically/emotionally abusive, loving, hostile):

CHILDREN/STEP/GRAND (names/ages and a brief statement re: your relationship with the person)

1._____

2._____

3._____

4._____

5._____

PARENTS/STEP-PARENT (Name/age or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship):

Father:_____

_____

_____

_____

Mother:_____

_____

_____

_____

Step-parents_____

_____

_____

_____

Other caregivers:_____

_____

_____

SIBLINGS (name/age, if dead: age and cause of death & brief statement about the relationship):

1._____

2._____

3._____

4._____

5._____

PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illnesses):

_____

_____

_____

SPECIFY MEDICATION you are presently taking, list dosages, and specify for what condition. PRINT clearly:

_____

_____

_____

ANY OTHER MEDICAL ISSUES:

_____

_____

_____

MAY I CONTACT YOUR PHYSICIAN(s)? Yes _____ No _____
PHYSICIANS' NAMES AND NUMBERS:

_____

•

•_____

_

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments)**: If yes, please describe:**

SUICIDE ATTEMPT/S or **VIOLENT BEHAVIOR** (describe: ages, reasons, circumstances, how, etc)

_____

_____

DO YOU CURRENTLY SMOKE? ___ DRINK? _____ OVER or UNDER-EAT?_____
If yes, please describe:

Asthma? ____ Migraines? ____ Major depressive episode? _____

If yes, how treated? _____

Manic episode? _____ If yes, how treated? _____

_____

Gastro-intestinal problems (ulcer, IBS, cramping, diarrhea, constipation):_____

_____

Skin problems?_____

FAMILY MEDICAL HISTORY (Describe any illness that runs in the family: cancer, epilepsy, etc)**:**

_____

_____

_____

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY (Describe quality, frequency, activities, etc.):

_____

_____

_____

_____

PAST/PRESENT PSYCHOTHERAPY (specify: month year/s (beginning—end), estimated number of sessions, therapist's name, phone & address, Initial reason for therapy, Ind/Couple/Family, medication, Brief description of the relationship and how helpful it was, and how/why it ended)**:**

_____

_____

_____

_____

_____

MAY I DISCUSS TREATMENT WITH ANY OF YOUR PRIOR THERAPISTS? (yes/no) _____
If yes, please list those names and numbers:

_____

_____

DESCRIBE YOUR CHILDHOOD IN GENERAL TERMS (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

IF PARENTS DIVORCED: Your age at the time: _____. Describe how it affected you then and now:

_____

_____

_____

_____

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, OR VIOLENCE (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

_____

_____

_____

_____

DEATHS IN THE FAMILY (Your age at the time and describe how it affected you)**:**

_____

_____

_____

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTE/S? (if Yes, please explain):

LIST THE TEN MOST UPSETTING OR DISTURBING TIMES, EVENTS, INCIDENTS OF YOUR LIFE BEGINNING WITH CHILDHOOD:

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

5. _____

_____

6. _____

_____

7. _____

_____

8 _____

_____

9. _____

_____

10. _____

_____

WHAT GIVES YOU THE MOST JOY OR PLEASURE IN YOUR LIFE?

_____

_____

WHAT ARE YOUR PREDOMINANT WORRIES OR FEARS?

_____

_____

WHAT ARE YOUR MOST IMPORTANT HOPES OR DREAMS?

_____

_____

Please add on the other side of this page or on a separate page any other information you would like me to know about you and your situation.

(continue on next page)

PLEASE CIRCLE ANY OF THE FOLLOWING THAT APPLY:

I have had a complete physical within the past 12 months

I currently feel suicidal and /or have a plan I think about

I drink alcohol

I take drugs not prescribed for me as medication for a medical condition(s)

I have been treated for chemical dependence or an eating disorder

I hear voices in my head or see things that are not there

In the past I have heard voices in my head or seen things that were not there

I have been hospitalized for a psychiatric reason or for chemical dependence
Date and name of facility _____

I have suffered from or been treated for seizures

I have an eye or vision problem unrelated to the need for glasses or contact lenses