BAY AREA
PSYCHOLOGY & COUNSELING

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Please complete **ALL** information on this form. It is important for your treatment that you be as detailed as possible!

Date of Appointment: _____

Name: _____ **Date of Birth**: _____

Social Security #: _____ **Age:** _____ **Gender:** _____ **Race:** _____

Marital Status: { } *Never Married* { } *Partnered* { } *Married* { } *Separated* { } *Divorced* { } *Widowed*

Address: _____ May we send mail there?

_____ { } Yes { } No

Home Phone: ( ) _____ May we leave a message? { } Yes { } No

Work Phone: ( ) _____ May we leave a message? { } Yes { } No

Cell Phone: ( ) _____ May we leave a message? { } Yes { } No

Email: _____ @ _____ May we email you? { } Yes { } No

*Please be aware that email may not be confidential.

Referred by: { } Self { } Friend { } Family { } Dr _____ { } Other _____

Please describe, in detail, the present problem (including when the problem started, how often it occurs, and what stressors may contribute to the problem, etc.) :

_____

_____

_____

_____

Has you received any previous treatment for the problem? { } Yes { } No If yes, please explain below.

Dates Treated By Whom or Where

_____

_____

_____

_____

Name of Primary Care Physician or Family Doctor: _____ Date last seen: _____

Please check any of the following stressors that presently affect, or recently affected you:

- ☐ Financial problems
- ☐ Family relationship problems
- ☐ Legal problems
- ☐ Child rearing problems
- ☐ Drug or alcohol problems
- ☐ Employment problems
- ☐ School problems
- ☐ Peer relationship problems
- ☐ Marital Problems

Please check any of the following medical conditions for which you were ever evaluated or diagnosed:

- ☐ Seizures
- ☐ Heart Problems
- ☐ Weight Problems
- ☐ Head Injury
- ☐ Asthma
- ☐ Chronic Fatigue
- ☐ Chronic Headaches
- ☐ Depression
- ☐ Surgeries
- ☐ Stomach Problems
- ☐ Suicidal Thoughts
- ☐ Chronic Hearing Loss

Please check any of the following medical conditions for which you show a family history:

- ☐ Seizures
- ☐ Heart Problems
- ☐ Weight Problems
- ☐ Sudden Death
- ☐ Asthma
- ☐ Chronic Fatigue
- ☐ Chronic Headaches
- ☐ Depression
- ☐ Obesity
- ☐ Diabetes Mellitus
- ☐ Suicidal Thoughts
- ☐ Heart Disease

Please indicate which, if any, of the following symptoms you are exhibiting:

ADHD	***Depression***	***Anxiety***	***Abuse***
Hyperactive	Sad	Excessive Worrying	Physical
Impulsive	Sleep Problems	Panic Attacks	Emotional
Under Achievement	Negative Thinking	Irrational Fear	Domestic Violence
Non-Compliant	Poor Concentration	Obsessions	Rape
Inattentive	Hopeless/Worthless	Social Isolation	Sexual
Poor Concentration	Mood Swings	Phobias	Dissociative
Disorganized	Guilt	Compulsive	
Self-Control	Fatigue/Lethargy	Shyness	

Relationship	***Anger***	***Addictions***	***Other***
Marital/ Significant Other	Short-fused	Alcohol	Agitated
Sexual Problems	Temper Tantrums	Drugs	Mania
Parenting	Impulse Control	Gambling	Paranoia
Difficulty With Friends	Violent/Assaultive	Relationships/Sex	Delusions
Work/School Problems	Runaway Risk	Eating Disorders	Tics/Tourettes
Personal Growth	Fighting	Cyber/Internet	Cutting Behavior
Grief/Loss	Irritable	Spending	Appetite Changes
Bullying/Teasing	Oppositional	Tobacco	Nightmares
			Flashbacks

Mental Health History

Have you ever had outpatient treatment? { } Yes { } No If yes, please explain below.

Reason Dates Treated By Whom or Where

_____

_____

_____

_____

Have you ever had inpatient treatment? { } Yes { } No If yes, please explain below.

Reason Dates Treated By Whom or Where

_____

_____

_____

_____

_____

Do you have a history of being abused emotionally, sexually, physically, or by neglect? { } Yes { } No

If yes, please describe when, where, and by whom? _____

_____

_____

Medical and Health Background

Do you have any current medical problems? { } Yes { } No

If yes, please list diagnoses: _____

_____

_____

Are you having trouble with your sleep? { } Yes { } No

If yes: { } Difficulty falling asleep { } Sleeping too much { } Waking up during the night

{ } Disturbing dreams { } Sleeping too little { } Not feeling refreshed

Are you having difficulties with your appetite or eating habits? { } Yes { } No

If yes: { } Eating less { } Eating more { } Restricting { } Binging or out-of-control eating { } Diminished appetite

Have you been hospitalized or had any surgical procedures? { } Yes { } No

If yes, when and for what: _____

_____

_____

How many times per week do you exercise? _____ How long each time? _____

What type(s) of exercise/activity: _____

Current Weight _____ **Height** _____ **Right or Left Handed** _____

List any Allergies that you may have: (if none, write "none)

_____

_____

_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth? { }Yes { } No

If yes, please describe _____

List all current prescription medications and how often you take them: (if none, write "none")

Medication Name	Dosage	Frequency	Estimated Start Date	Doctor

Current over-the-counter medications or supplements: _____

_____

Childhood History and Family Background

Were you adopted? { } Yes { } No

Where were you born? _____ **Where did you grow up**? _____

Mother: Name _____ Age _____ Occupation _____

If deceased- Age _____ Cause of Death _____

Father: Name _____ Age _____ Occupation _____

If deceased- Age _____ Cause of Death _____

Siblings: (Name and list ages from oldest to youngest) _____

_____

Did your parents divorce? { } Yes { } No

If yes, how old were you? _____ With whom did you live? _____

Please identify below if there is a family history of any of the following:

	CHECK ONE	LIST FAMILY MEMBER
Alcohol/Substance Abuse	{ } Yes { } No	
Anger Management Issues	{ } Yes { } No	
Anxiety	{ } Yes { } No	
Bipolar Disorder	{ } Yes { } No	
Depression	{ } Yes { } No	
Domestic Violence	{ } Yes { } No	
Eating Disorders	{ } Yes { } No	
Obesity	{ } Yes { } No	
Obsessive Compulsive Behavior	{ } Yes { } No	
Personality Disorders	{ } Yes { } No	
Post Traumatic Stress Disorder	{ } Yes { } No	
Schizophrenia	{ } Yes { } No	
Suicide Attempts	{ } Yes { } No	

Relationship History and Current Family

Are you currently married or involved in an intimate relationship ? { } Yes { } No

If yes, Name _____ How long? _____

What is your spouse or significant other's occupation? _____

Have you had any prior marriages? { } Yes { } No

If yes, how many and how long for each _____

Do you have any children? { } Yes { } No

If yes, list ages and gender from oldest to youngest _____

_____

Educational History

Did you graduate high school? { } Yes **Where**? _____ **Year**? _____

{ } No **Last grade completed? ___ Where? _____ Year? _____**

Are you currently enrolled in school? { } Yes { } No

If yes, where? _____ Grade? _____

Did you attend college? { } Yes { } No

If yes, highest degree obtained? _____ Major? _____

Where? _____ Year? _____

Please identify any school-related problems:

{ } Inattentiveness { } Bullying { } School-related anxiety { } Refusing to do or complete work

{ } Refusal to attend { } Being bullied { } Suspensions or Expulsion { } Current problems with truancy

Is there a history of an IEP or Special Education Placement? { } Yes { } No

Is there a history of repeated grades or courses? { } Yes { }No

If yes, which ones? _____

Employment History

Are you currently: { } Working { } Student { } Unemployed { } Disabled { } Retired

How long in your present position? _____

What is/was your occupation? _____

Name of employer? _____

Have you ever served in the military? { } Yes { } No

If yes, What branch? _____ When? _____

Honorable Discharge? { } Yes { } No { } Other Discharge _____

Legal History

Have you ever been arrested? { } Yes { } No

If yes, date of arrest _____ Charge _____ Punishment _____

date of arrest _____ Charge _____ Punishment _____

date of arrest _____ Charge _____ Punishment _____

Do you have any current, pending, or expected future legal issues? { } Yes { } No

If yes, please explain _____

_____

_____

Substance Use

Have ever tried the following:

If yes, how long and when did you last use?

Methamphetamine { } Yes { } No
Cocaine { } Yes { } No
Stimulants (pills) { } Yes { } No
Heroin { } Yes { } No
LSD or Hallucinogens { } Yes { } No
Marijuana { } Yes { } No
Pain killers (not as prescribed) { } Yes { } No
Methadone { } Yes { } No
Tranquilizer/sleeping pills { } Yes { } No
Ecstasy { } Yes { } No
Other _____

Have you ever been treated for alcohol or drug use or abuse? { } Yes { } No

If yes, for which substances? _____

where were you treated and when? _____

How many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____ What is the most? _____

Have you ever abused prescription medication? { } Yes { } No

If yes, which ones and for how long? _____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

How you ever smoked cigarettes? { } Yes { } No

Currently? { } Yes { } No How many packs per day on average? _____ How many years? _____

In the past? { } Yes { } No How many years did you smoke? _____ When did you quit? _____

Have you ever used pipe, cigars, or chewing tobacco: Currently? { } Yes { } No In the past? { } Yes { } No

What kind? _____ How often per day on average? _____ How many years? _____

Social and Cultural History

Do you consider yourself to be spiritual or religious? { } Yes { } No

If yes, what is the level of your involvement? _____

Please state or describe your faith or belief _____

Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? { } more helpful { } more stressful

Are there any ethnic or cultural practices or beliefs which we need to be aware of? { } Yes { } No

If yes, please describe _____

Which areas of your life are going well? _____

Favorite hobbies or activities: _____

Favorite movies, books, or TV shows: _____

Name of person completing form (if not the patient): _____ Date: _____

Appointment Policy:

I understand that when an appointment is scheduled for me, a specific period of time is set-aside just for me. If I am late, my session cannot be extended beyond the time reserved for me because it would infringe on the next patient's appointment time. I understand that I will be charged the amount for a complete session.

I understand that I am responsible for providing at least a 48-hour notice to cancel an appointment. I understand that I will be billed a late cancellation/no show charge for all missed appointments not cancelled at least 48 hours in advance.

Signature: _____ Date: _____

Payment Policy:

It is the policy of this office to request payment at the time services are provided. We are available to assist in the billing of your insurance carrier and will accept assignment of benefits on your behalf. However, your insurance policy is a contact between you, your carrier, and possibly, your employer. The fees for services provided to the patient are part of a contract between you and this office. Therefore, you will be responsible for the fees, including those not paid for any reason by your insurance carrier.

If you have insurance, final determination of your copay (cost share) will be established by the actual payment made by your insurance company. You will be responsible for the difference between what your insurance pays and the fees set by this office (or the maximum fee set by your insurance company).

Insurance companies do not pay for reports, letter writing, telephone consultations, school consultations, or legal proceedings. While certain correspondence will be provided as a courtesy (i.e. a brief letter to excuse someone from work or school), other, more involved correspondence prepared at your request, the request of an attorney or outside agency or ordered by the court will result in a fee for time involved, in much the same way that an attorney or accountant would charge you for services rendered. If the psychological services requested are for matters involving legal proceedings, i.e. custody, visitation, probation, expert testimony, etc., a retainer may be required. You will be expected to pay for the professional time required even if I am compelled to testify by another party.

Your signature below signifies that you have read and understood the above.

Signature: _____ Date: _____

Name of Responsible Party for Payment: _____ Relation to Patient: _____

Responsible Party's Signature: _____ Date: _____

Confidentiality Policy:

Everything you say to your doctor is confidential, which means that it is private and cannot be shared with anyone outside this office without your permission. Your doctor cannot release any information about you without a signed consent for release of information, except in emergencies or when ordered by the court. Please note that information about dangerous behaviors, including serious thoughts of hurting yourself or someone else, as well as information about possible child abuse, is not confidential and will be reported by your doctor to the appropriate authorities to keep you and other people safe.

If you were referred by a court order, information about your treatment is not confidential and will be released to the court, regardless of your permission. Additionally, requests for psychological evaluations and/or psychotherapy by an employer or workman's compensation agency require that the information obtained by released to these agencies regardless of your permission as they are the ones paying for the appointment(s).

Your signature below signifies that you have read and understood the above.

Signature: _____ Date: _____

If you are over the age of 18, please list any additional people who can have access to obtain information about your medical record, schedule appointments, or attend sessions.

1. **Name: _____ Phone #: _____**
2. **Name: _____ Phone #: _____**
3. **Name: _____ Phone #: _____**
4. **Name: _____ Phone #: _____**
5. **Name: _____ Phone #: _____**

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