



Clinical Psychology

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Clinical Information

A. Identification

Name _____ Date: _____

B. Chief concern

Please describe the main difficulty that has brought you to see me: _____

C. Treatment

1. Have you ever received psychological or psychiatric or counseling services before? No Yes If yes, please indicate:

When?	From whom?	For what?	With what results?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. Have you ever taken medications for psychiatric or emotional problems? No Yes If yes, please indicate:

When?	From whom?	Which medications	For what	With what results?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

D. Relationships in your family of origin. Please describe the following:

1. Your parents' relationship with each other: _____

2. Your relationship with each parent and with other adults present: _____

3. Your parents' physical health problems, chemical use, and mental or emotional difficulties: _____

4. Your relationship with your brothers and sisters, in the past and present: _____

E. Abuse history: I was not abused in any way. I was abused. If you were abused, please indicate the following. For kind of abuse, use these letters: P = Physical, such as beatings. S = Sexual, such as touching/molesting, fondling, or intercourse. N = Neglect, such as failure to feed, shelter, or protect you. E = Emotional, such as humiliation, etc.

Your age	Kind of abuse	By whom?	Effects on you?	Whom did you tell?	Consequences of telling?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

F. Present relationships

1. How do you get along with your present spouse or partner? _____

2. How do you get along with your children? _____

3. Your important friends, past and present:

Names	Good parts of relationship	Bad parts of relationship
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

G. Chemical use

1. Have you ever felt the need to cut down on your drinking? No Yes

2. Have you ever felt annoyed by criticism of your drinking? No Yes

3. Have you ever felt guilty about your drinking? No Yes

4. Have you ever taken a morning "eye-opener"? No Yes

5. How much beer, wine, or hard liquor do you consume each week, on the average? _____

6. How much tobacco do you smoke or chew each week? _____

7. Which drugs (not medications prescribed for you) have you used in the last 10 years? _____

Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects, and so forth: _____

H. Legal history

1. Are you presently suing anyone or thinking of suing anyone? No Yes If yes, please explain:

2. Is your reason for coming to see me related to an accident or injury? No Yes If yes, please explain:

3. Are you required by a court, the police, or a probation/parole officer to have this appointment?

No Yes If yes, please explain: _____

4. Your current attorney's name: _____ Phone: _____

5. Are there any other legal involvements I should know about? _____

I. Other

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper:

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