



Name _____ S.S.# _____

Address _____
Street State Zip

Phone: Home _____ Cell _____ Work _____

Age _____ Birthdate _____ Marital Status _____ Gender _____

Years of school completed _____ Highest Degree _____ Major _____

May we contact you at home? _____ at work? _____ Email _____

Who referred you? _____

MEDICAL

Name of physician _____ Date of last exam _____

Major health problems _____

Medications _____

Surgeries/ when? _____

INSURANCE

Policyholder's name Employer Policyholder's birthdate

Insurance Company Policyholder's SS# Policy Number

Responsible Party (if other than client) _____

Address _____

Emergency Contact _____ Phone number _____

ASSIGNMENT OF BENEFITS:I request that payment of private insurance and/or government benefits for my treatment be made to Chestnut Park Professionals, LLC.

***Signature of client or his/her representative** _____

CONSENT TO TREATMENT: I consent that I, or the person whom I represent, receive psychological treatment from Chestnut Park Professionals, LLC

***Signature of client or his/her representative _____ Date _____**

Please answer the following questions. Your answers will help us help you. You may skip questions when you prefer not to answer.

Reason(s) for seeking psychological help: _____

Previous psychological or psychiatric treatment _____

Hospitalizations with dates _____

What is causing you stress? _____

Check any of the following that apply to you:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Sleeplessness | <input type="checkbox"/> Isolating | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Too much energy |
| <input type="checkbox"/> Sleeping too much | <input type="checkbox"/> Depression | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Temper Outbursts |
| <input type="checkbox"/> Crying | <input type="checkbox"/> Feeling worthless | <input type="checkbox"/> Problem thoughts | <input type="checkbox"/> Aggressive behavior |
| <input type="checkbox"/> Sadness | <input type="checkbox"/> Feeling hopeless | <input type="checkbox"/> Compulsions | <input type="checkbox"/> Impulsive reactions |
| <input type="checkbox"/> Grief | <input type="checkbox"/> Death wishes | <input type="checkbox"/> Obsessions | <input type="checkbox"/> Take too many risks |
| <input type="checkbox"/> Too little energy | <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Appetite problems | <input type="checkbox"/> Can't keep a job |
| <input type="checkbox"/> Low motivation | <input type="checkbox"/> Worrying | <input type="checkbox"/> Eating problems | <input type="checkbox"/> Drink too much alcohol |
| <input type="checkbox"/> Memory problems | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Relationship | <input type="checkbox"/> Illegal drugs |
| <input type="checkbox"/> Concentration problems | <input type="checkbox"/> Fears | <input type="checkbox"/> Sexual problems | <input type="checkbox"/> Other _____ |

Check any of the following that often apply to you:

- | | | | | | |
|----------------------------------|------------------------------------|-------------------------------------|------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Angry | <input type="checkbox"/> Fearful | <input type="checkbox"/> Happy | <input type="checkbox"/> Hopeful | <input type="checkbox"/> Bored | <input type="checkbox"/> Optimistic |
| <input type="checkbox"/> Annoyed | <input type="checkbox"/> Panicked | <input type="checkbox"/> Conflicted | <input type="checkbox"/> Helpless | <input type="checkbox"/> Restless | <input type="checkbox"/> Tense |
| <input type="checkbox"/> Sad | <input type="checkbox"/> Energetic | <input type="checkbox"/> Shameful | <input type="checkbox"/> Relaxed | <input type="checkbox"/> Lonely | <input type="checkbox"/> Shy |
| <input type="checkbox"/> Envious | <input type="checkbox"/> Regretful | <input type="checkbox"/> Jealous | <input type="checkbox"/> Contented | <input type="checkbox"/> Anxious | <input type="checkbox"/> Unassertive |
| <input type="checkbox"/> Guilty | <input type="checkbox"/> Hopeless | <input type="checkbox"/> Unhappy | <input type="checkbox"/> Excited | <input type="checkbox"/> Other feelings _____ | |

Describe any mood problems you have _____

Women: Do you menstrual periods affect your moods? _____ Date of last period _____

Do you ever think about killing yourself? No ___ Yes ___ If yes describe _____

Have you ever attempted suicide? No ___ Yes ___ If yes describe _____

Have you ever deliberately hurt yourself? Explain _____

Have you ever seen or heard things that were not there? _____

Have you ever thought that others were trying to harm you? Explain _____

Are you bothered by thought that occurs over and over again? No ___ Yes _____

Do you have trouble relaxing or enjoying weekends and vacations? No ___ Yes ___ If yes, explain _____

Have you ever had any eating disorder problems? No___ Yes___ If yes, describe:

Do you drink alcohol? No___ Yes___ How much/ often? _____
Do you have a history of substance abuse? No___ Yes___ If yes, please describe and list any S.A. treatment you have received _____

FAMILY HISTORY

Where were you born and raised? _____

Was there anything unusual about your early development? _____

Father's age___ Occupation_____ Health_____ If deceased, give his age at time of death___ Cause of death_____ Your age at the time_____

Mother's age___ Occupation_____ Health_____ If deceased, give her age at time of death___ Cause of death_____ Your age at the time_____

Siblings: Name and ages of brothers and/or sisters: _____

Give significant details about siblings and describe how you get along with them _____

Were you brought up by your parents?_____ If not, who raised you? _____

Describe your relationship with each parent _____
How good was your childhood? _____

If your parents divorced how old were you?_____ If one or both remarried how old were you? _____

Describe your relationship with your stepparents _____

Is there any history of substance abuse or psychiatric problems in your family history? No___ Yes___
If yes, please describe _____

Has anyone outside or inside your home abused you physically?_____ verbally_____ sexually_____?

FAMILY

Are you married?_____ years of marriage_____ Spouse's age_____
Spouse's occupation _____

How satisfied are you with your marriage? Very Dissatisfied 1 2 3 4 5 6 7 Very satisfied

Are you divorced?_____ When?_____ Years of marriage_____
Ex-spouse's occupation _____

Are you widowed?_____ Cause of spouse's death _____ When _____
Years of marriage _____

Number of previous marriages and any significant details _____

Names and ages of children _____

Please describe any special problems presented by your children _____

OTHER

How long have you worked at your current job? _____ How satisfied are you with your work? _____

List jobs you've held in the past _____

Describe any problems in your work relationships _____

Do you exercise regularly? _____ If yes, what type and how often? _____

Have you ever smoked? _____ If yes, when did you start? _____ When did you last smoke? _____

Have you ever been in a fight? _____ How often do you get in fights? _____ Date of last fight _____

If you have had any legal problems, describe what and when: _____

How do you spend your free time? _____

Do you make friends easily? _____ Do you wish you had more friends? _____

How do you calm yourself when stressed? _____

List the persons available to you when you need social support: _____

Do you have an active faith life? _____ If you attend church, where and how often? _____

What do you like about yourself? _____

What changes would you like to see in yourself, personal life? _____

What changes would you like to see in your relationships (family, friends, work)? _____

Additional relevant information: _____
