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Adult Psychological History

Date of Appointment: _____

Name of person filling out form:_____ Relationship to patient:_____

Patient Name: _____ Sex: _____ Age: _____ Date of Birth: _____

Social Security #:_____ Home Address: _____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email:_____ Employer:_____

Referred By: _____ Reason For Referral:_____

Litigation pending?_____ Attorney: _____ Phone: _____

History of Present Problem

How long ago did problems begin: _____

Please describe the problems that you want help with:_____

Birth and Developmental History

Place of Birth:_____ Were parents married at time of birth? _____
Was mother under a doctor's care? _____ Were you adopted?_____ If so, at what age? _____

Check any illnesses during your mother's pregnancy:
☐ Anemia ☐ Toxemia ☐ Herpes ☐ Measles ☐ German measles ☐ Bleeding
☐ Kidney disease ☐ Heart disease ☐ Hypertension ☐ Abdominal trauma ☐ Infection ☐ Diabetes

Medications taken during pregnancy:_____
Were drugs or alcohol taken during pregnancy? ☐ Yes ☐ No If yes, specify:_____
Was there significant emotional stress during pregnancy? ☐ Yes ☐ No If yes, name stressors: _____

Was the birth: ☐ On time ☐ Premature (By how long _____) ☐ Late (By how long) :_____
Was labor: ☐Spontaneous ☐ Induced Duration of labor___ (Hours) ☐ Cesarean required ☐ Cesarean planned
Was the presentation: ☐ Normal ☐ Breach ☐ Transverse (Crosswise) ☐ Posterior first
Did the baby experience any of these problems: ☐ Fetal distress ☐ Prolapsed cord ☐ Placenta previa
☐ Premature separation of the placenta (Abruptio placenta) ☐ Cord wrapped around neck
Any other problems that mother or child had: _____ Was general anesthesia used: ☐Yes ☐No
Were forceps used? ☐Yes ☐No Were there breathing problems? ☐Yes ☐ No
Color at birth: ☐ Normal ☐ Blue ☐ Yellow Was oxygen used ☐ Yes ☐ No (How long)? _____
APGAR Score _____Birthweight: _____ Length: _____

Check those that apply to the first few weeks after birth:
☐ Excessive sleeping ☐ Laziness ☐ Irritability ☐ Excessive crying ☐ Stiffness ☐ Limpness ☐ Tremors
☐ Twitching ☐ Feeding difficulties ☐ Vomiting ☐ Jaundice Other:_____
Transfusions required? ☐Yes ☐No Medication required? ☐Yes ☐No
Surgery required? ☐Yes ☐No (Why)_____

Give approximate ages that developmental milestones were achieved:
Head control _____Rolled over_____Sat alone _____Walked _____Run _____
Said first word _____Used sentences _____Self feeding w/ utensils _____ Toilet trained _____
Dress self _____ Tie shoes _____Color within lines _____First menstruation/onset of puberty:_____

Check any problems that occurred in later development:
☐ Hearing ☐ Speaking ☐ Stuttering ☐ Reading ☐ Writing ☐ Spelling ☐ Arithmetic
☐ Behavior ☐ Hyperactivity ☐ Seizures ☐ Coordination ☐ Attention difficulties

List family members with developmental or learning problems:_____

DOCTOR'S NOTES

Medical History

Please check all the conditions that have been diagnosed as a child or an adult.

- ☐ AIDS, ARC or HIV
- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Abscessed ears
- ☐ Arteriosclerosis
- ☐ Bleeding disorder
- ☐ Blood disorder
- ☐ Broken bones
- ☐ Brain Injury
- ☐ Cerebral palsy
- ☐ Colds (excessive)
- ☐ Chicken pox
- ☐ Carbon monoxide
- ☐ Cancer
- ☐ Diabetes
- ☐ Enzyme deficiency
- ☐ Encephalitis
- ☐ Ear Infections
- ☐ Fevers (104 or higher)
- ☐ Genetic disorder
- ☐ Head injury/Concussion
- ☐ Heart problems
- ☐ Hereditary disorder
- ☐ Headaches
- ☐ Hearing problems
- ☐ Huntington's disease
- ☐ Hypertension
- ☐ Hormone problems
- ☐ Hazardous Substance
- ☐ Immune system
- ☐ Jaundice
- ☐ Kidney problems
- ☐ Liver disorder
- ☐ Lung disease
- ☐ Lead poisoning
- ☐ Leukemia
- ☐ Metabolic disorder
- ☐ Meningitis
- ☐ Measles
- ☐ Mumps
- ☐ Malnutrition
- ☐ Multiple sclerosis
- ☐ Oxygen deprivation
- ☐ Pneumonia
- ☐ Poisoning
- ☐ Polio
- ☐ Parkinson's disease
- ☐ Rheumatic Fever
- ☐ Radiation Exposure/Therapy
- ☐ Scarlet Fever
- ☐ Senility (Dementia)
- ☐ Stroke or TIA
- ☐ Tuberculosis
- ☐ Tumor
- ☐ Thyroid disease
- ☐ Venereal disease
- ☐ Vision problems
- ☐ Whooping cough
- ☐ Other medical/physical _____

Have you ever been diagnosed with epilepsy or a seizure disorder? ☐ Yes ☐ No If yes, check the one you have been diagnosed with.

PARTIAL
- ☐ Simple partial
- ☐ Complex partial
- ☐ Partial evolving into generalized

GENERALIZED
- ☐ Absence (Petit mal)
- ☐ Myonclonic
- ☐ Clonic
- ☐ Tonic
- ☐ Tonic-clonic (Grand mal)
- ☐ Atonic

☐ UNCLASSIFIED

Medication and dosage:

List any medications currently being taken (over-the-counter or prescription), and the dosage

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

List any medications you are ALLERGIC or sensitive to: _____

Past Hospitalizations (When, where and for what):

_____
_____
_____

Outpatient Surgeries (When, where and for what):

_____
_____
_____

Name of family physician: _____
Address: _____
Phone: _____ Date of your last medical check-up: _____

Medical Testing

Check all medical tests that recently have been done and report any abnormal findings:

☐ Angiography	☐	_____
☐ Blood work	☐	_____
☐ Magnetic Resonance Imaging (MRI)	☐	_____
☐ CT scan	☐	_____
☐ PET scan	☐	_____
☐ EKG	☐	_____
☐ EEG	☐	_____
☐ Lumbar puncture or spinal tap	☐	_____
☐ Neurological office exam	☐	_____
☐ Physician's office exam	☐	_____
☐ X-ray	☐	_____
☐ Ultrasound	☐	_____
☐ Other testing: _____	☐	_____

DOCTOR'S NOTES

Psychiatric History

Place a check to indicate if any problems apply currently (in the last six months) or in the past.

Current	Past		Current	Past	
☐	☐	Suicidal thoughts (date?_____)	☐	☐	Homicidal thoughts (date?_____)
☐	☐	Depression/sadness	☐	☐	Anxiety/nervousness
☐	☐	Difficulty sleeping	☐	☐	Nightmares
☐	☐	Overeating	☐	☐	Loss of appetite
☐	☐	Weight gain	☐	☐	Weight loss
☐	☐	Visual/auditory hallucinations	☐	☐	Sexual Problems
☐	☐	Anorexia/Bulimia	☐	☐	Apathy
☐	☐	Rapid mood changes	☐	☐	Explosive anger
☐	☐	Decreased need for sleep	☐	☐	Euphoria (feel on top of the world)
☐	☐	Distractible	☐	☐	Racing thoughts
☐	☐	Fatigue	☐	☐	Feeling worthless
☐	☐	Poor self-esteem	☐	☐	Loss of interest in almost all activities
☐	☐	Overwhelming need to perform certain behaviors/rituals	☐	☐	Recurrent/intrusive disturbing recollections/dreams
☐	☐	Significant concerns with physical problems	☐	☐	Excessive fears or phobias

Indicate which stressors you are experiencing currently (within the last 6 months) or in the past.

Now	Past		Now	Past		Now	Past	
☐	☐	Death of spouse	☐	☐	Death of family member	☐	☐	Illness of family member
☐	☐	Illness of friend	☐	☐	Personal injury/illness	☐	☐	Marital difficulties
☐	☐	Marital separation	☐	☐	Divorce	☐	☐	Sexual Difficulties
☐	☐	Conflicts with family	☐	☐	Conflicts with friends	☐	☐	Conflicts at work
☐	☐	New Job	☐	☐	Job termination	☐	☐	Retirement
☐	☐	Business difficulties	☐	☐	Academic difficulties	☐	☐	Financial problems
☐	☐	Change in residence	☐	☐	Legal problems	☐	☐	Sexual assault
☐	☐	Incest/sexual abuse	☐	☐	Physical abuse	☐	☐	Verbal/emotional abuse
☐	☐	Other problems: _____						

Are you currently receiving therapy? ☐ Yes ☐ No From who?_____
When did you start therapy?_____ For what problems(s)?_____
List current psychiatric medications:_____
Prescribed by who? _____
Have you received therapy in the past? ☐ Yes ☐ No From who?_____
When (Start and finish):_____ For what problem(s)?_____
_____
List past psychiatric medications:_____
Have you been hospitalized for psychological problems? ☐ Yes ☐ No When?_____
Where were you hospitalized?_____
Have you ever attempted suicide? ☐ Yes ☐ No When?_____ How?_____

Have you had a prior psychological or neuropsychological evaluation? ☐ Yes ☐ No If yes, complete this information:
Name of psychologist: _____
Address: _____
Phone:_____ Date of and reason for this evaluation:_____
Findings of the evaluation: _____

Substance Use History

Current Past (Even if only occasionally or in small amounts):

☐ ☐ Alcohol What do you drink? ☐Beer ☐Wine ☐Mixed Drink ☐ Hard Liquor
How Often? _____ How Many? _____
DUI? ☐ Yes ☐ No Accidents? ☐ Yes ☐ No Missed work or school? ☐ Yes ☐ No
Risky Behavior ☐ Yes ☐ No If so, what? _____

☐ ☐ Tobacco How Much? _____ How Often? _____ When did you quit? _____

☐ ☐ Marijuana

☐ ☐ Barbiturates ("Downers")

☐ ☐ Tranquilizers

☐ ☐ Amphetamines ("Speed")

☐ ☐ Crank

☐ ☐ Crack

☐ ☐ Cocaine

☐ ☐ Opiates (Heroine, Opium, Codeine, etc.)

☐ ☐ Hallucinogenic (LSD, STP, "Magic Mushrooms", etc.)

☐ ☐ PCP ("angel dust")

☐ ☐ Ecstasy

☐ ☐ Other: _____

DOCTOR'S NOTES

Family History

Father's Name _____ Age _____ Health Problems _____
Education _____ Occupation _____ Employer _____
Mother's Name _____ Age _____ Health Problems _____
Education _____ Occupation _____ Employer _____
Date of parent's marriage _____ Years married _____ Current marital problems? _____
If separated, give date _____ If divorced, date _____
Previous marriages? (Father) _____ (Mother) _____Subsequent marriages? (Father) ____ (Mother) _____

Please provide information regarding step-parents if your parents are divorced:

Name	Age	Education	Occupation	Date Married	# Years

Names and ages of brothers and sisters (Include step-brothers and step-sisters):

_____
_____
_____
_____

List anyone else who lived in the home during your childhood: _____

List any biologically related family members with any of the following problems:
Alcohol/Drug Abuse _____
Criminal History: _____
Emotional/behavior problems: _____
Medical problems (e.g. Heart disease, Cancer, Seizures) _____
Learning/developmental problems: _____

DOCTOR'S NOTES

Marital History

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Current Marriage

Date of marriage:_____ Number of years married: _____ Date of separation:_____
Spouse's name: _____ Age:_____ Health:_____
Education: _____ Occupation: _____ Type of marital problems: _____
Names and ages of children: _____
If separated, what is the custody arrangement: _____

Prior Marriage

Date of marriage:_____ Date of separation:_____ Date of divorce:_____
Spouse's name: _____ Age:_____ Health:_____
Education: _____ Occupation: _____ Type of marital problems: _____
Names and ages of children: _____
What is the custody arrangement: _____

Prior Marriage

Date of marriage:_____ Date of separation:_____ Date of divorce:_____
Spouse's name: _____ Age:_____ Health:_____
Education: _____ Occupation: _____ Type of marital problems: _____
Names and ages of children: _____
What is the custody arrangement: _____

List any other marriages and children:

_____
_____

List names of spouses or children with the following problems:
Developmental Learning Problems: _____
Emotional/Behavioral problems: _____
Alcohol/Drug abuse: _____
Medical Problems: _____

DOCTOR'S NOTES

Social History

If single or separated, are you currently dating anyone? _____How long? _____Is it a serious relationship? _____
First name: _____ Are you currently sexually active? _____ If not dating, when was your last date? _____
How long did you date that person? _____Was it a serious relationship? _____First name: _____

Please list "significant others" you have lived with but not married.

Current/Most Recent Cohabitation

Date began:_____ Number of years together:_____ Date ended:_____
Name :_____ Age:_____ Health: _____
Education: _____ Occupation: _____ Type of relationship problems: _____
Names and ages of children: _____
If separated, what is the custody arrangement: _____

Prior Cohabitation

Date began:_____ Number of years together:_____ Date ended:_____
Name :_____ Age:_____ Health: _____
Education: _____ Occupation: _____ Type of relationship problems: _____
Names and ages of children: _____
If separated, what is the custody arrangement: _____

Have you lived with anyone else in the past? ☐Yes ☐No How many times?_____
Any other children outside of marriage? ☐Yes ☐No Names/Ages: _____
Any aborted pregnancies/miscarriages? ☐Yes ☐No When? _____

List clubs and community business organizations you are involved with and how often you attend: _____
_____
Do you attend church? ☐Yes ☐No (where and how often) : _____
What do you do with your free time (including hobbies and extracurricular interests): _____
When was your last vacation (Please describe): _____
How many close friends do you have in the community: _____How often do you get together with friends or family: _____
How long have you lived in the community: _____ Where have you lived in the past: _____

DOCTOR'S NOTES

Educational History

Current grade/highest grade or degree completed: _____ Current school: _____
Past schools attended (List in order): _____
Hardest subject(s): _____ Favorite subject(s): _____
Grades in elementary school: _____ Junior High G.P.A. _____ High School GPA _____ College GPA _____
Grades repeated: _____ Learning problems (what subjects): _____
Special education placement (Type): _____ During which grades: _____
Extracurricular activities (Music, Sports, Clubs, etc.) _____
Expulsions/suspensions/conduct problems (Type of problem and date): _____
Additional schooling or non-academic training: _____

DOCTOR'S NOTES

Occupational History

Present employer: _____ Position: _____
Length of employment: _____ Hours worked per week _____ Current responsibilities: _____

List previous employment for last ten years (Include dates and type of work):_____
_____

Have you ever been terminated from a job (Please explain):_____
At any time on the job were you ever exposed to dangerous chemicals or substances (e.g., Mercury, Lead, Radiation, Solvents, Pesticides, Chemicals, etc.)? ☐ Yes ☐ No If yes, explain: _____
Have you ever been injured on the job? ☐ Yes ☐ No If yes, explain: _____

DOCTOR'S NOTES

Legal History ☐ Not Applicable

Present legal problems (Describe): _____
Past arrests (For what?): _____
Convictions (For what?): _____
Time served in juvenile hall, jail or prison (Give dates and locations): _____

DOCTOR'S NOTES

Military Service ☐ Not Applicable

Branch of service: _____ Dates of service: _____ Job(s) within service: _____
Highest rank: _____ Rank at discharge: _____ Discharge status: _____
Were you exposed to any dangerous or unusual substances (e.g. Agent Orange, Radiation, etc.) ☐Yes ☐No
If yes, explain: _____
Did you sustain any physical injuries in the military? ☐Yes ☐No If yes, explain: _____

DOCTOR'S NOTES

General Symptom Checklist

Please rate yourself on each of the symptoms listed below using the following scale. If possible, please have another person who knows you well (such as a spouse or roommate) rate you also to help provide a complete picture of you. Name of other person: _____

0 Never **1 Rarely** **2 Occasionally** **3 Frequently** **4 Very Frequently** **N/A Not Applicable Not Known**

Self	Other	Descriptor	
___	___	Depressed or sad mood	
___	___	Decreased interest in things that are usually fun, including sex	
___	___	Significant **recent** weight gain or loss, or marked appetite changes, increased or decreased	
___	___	Recurrent thoughts of death or suicide	
___	___	Sleep changes, lack of sleep or marked increase in sleep	
___	___	Physically agitated or "slowed down"	
___	___	Low energy or feelings of tiredness	
___	___	Feelings of worthlessness, helplessness, or guilt	
___	___	Decreased concentration or memory	MD 5
___	___	Periods of an elevated, high or irritable mood	
___	___	Periods of a very high self-esteem or grandiose thinking	
___	___	Periods of decreased need for sleep **without** feeling tired	
___	___	More talkative **than usual** or pressure to keep talking	
___	___	Fast thoughts or frequent jumping from one subject to another	
___	___	Easily distracted by irrelevant things	
___	___	Marked increase in activity level	
___	___	Excessive involvement in pleasurable activities which have the potential for painful consequences (spending Money, sexual indiscretions, gambling, foolish business ventures)	BD 4
___	___	Panic attacks, which are periods of intense, unexpected fear or emotional discomfort (#/mo____)	
___	___	Periods of trouble breathing or feeling smothered	
___	___	Periods of feeling dizzy, faint or unsteady on your feet	
___	___	Periods of heart pounding or rapid heart rate	
___	___	Periods of sweating	
___	___	Periods of choking	
___	___	Periods of nausea or abdominal upset	
___	___	Feelings of a situation "not being real"	
___	___	Numbness or tingling sensations	
___	___	Hot or cold flashes	
___	___	Periods of chest pain or discomfort	
___	___	Intense fear of dying	
___	___	Fear of going crazy or doing something uncontrolled	PD 18, 4
___	___	Avoiding everyday places for fear of having a panic attack or needing to go with other people in order to feel comfortable	
___	___	Excessive fear of being judged by others which causes you to avoid or get anxious in situations	
___	___	Persistent, excessive fear of ☐ heights ☐ closed spaces ☐ specific animals ☐ other: _____	

General Symptom Checklist

0 Never	1 Rarely	2 Occasionally	3 Frequently	4 Very Frequently	N/A Not Applicable Not Known

Self	Other	Descriptor		
___	___	Recurrent bothersome thoughts, ideas or images which you try to ignore		
___	___	Trouble getting "stuck" on certain thoughts, or having the same thought over and over		
___	___	Excessive or senseless worrying		
___	___	Others complain that you worry too much or get "stuck" on the same thoughts		
___	___	Compulsive behaviors that you must do or you become very anxious such as excessive hand washing, Checking locks, or counting or spelling		
___	___	Needing to have things done a certain way or you become very upset		
___	___	Others complain that you do the same thing over and over to an excessive degree (e.g. cleaning or checking	OC	3
___	___	Recurrent and upsetting thoughts of a past traumatic event (molest, accident, fire, etc.)Please list: _____		
___	___	Recurrent distressing dreams of a past event		
___	___	A sense of reliving a past upsetting event		
___	___	A sense of panic or fear to events that resemble an upsetting past event		1
___	___	You spend effort avoiding thoughts or feelings associated with a past trauma		
___	___	Persistent avoidance of activities/situations which cause remembrance of upsetting event		
___	___	Inability to recall an important aspect of a past upsetting event		
___	___	Marked decreased interest in important activities		
___	___	Feeling detached or distant from others		
___	___	Feeling numb or restricted in your feelings		
___	___	Feels that your future is shortened		3
___	___	Startles easily		
___	___	Feels like you are always watching for bad things to happen		
___	___	Marked physical response to events that remind you of a past upsetting event (i.e. sweating when getting In a car if you had been in a car accident)	PTS	2
___	___	Trembling, twitching or feeling shaky		
___	___	Muscle tension, aches or soreness		
___	___	Feelings of restlessness		
___	___	Easily fatigued		
___	___	Shortness of breath or feeling smothered		
___	___	Heart pounding or racing		
___	___	Sweating or cold clammy hands		
___	___	Dry mouth		
___	___	Dizziness or lightheadedness		
___	___	Nausea, diarrhea or other abdominal distress		
___	___	Hot or cold flashes		
___	___	Frequent urination		
___	___	Trouble swallowing or "lump in throat"		
___	___	Feeling keyed up or on edge		
___	___	Quick startle response of feeling jumpy		
___	___	Difficulty concentrating or "mind going blank"		
___	___	Trouble falling or staying asleep		
___	___	Irritability	GAD	6

General Symptom Checklist

0 Never	1 Rarely	2 Occasionally	3 Frequently	4 Very Frequently	N/A Not Applicable Not Known

Self	Other	Descriptor		
___	___	Trouble sustaining attention or being easily distracted		
___	___	Difficulty completing projects		
___	___	Feeling overwhelmed of the tasks of everyday living		
___	___	Trouble maintaining an organized work or living area		
___	___	Inconsistent work performance		
___	___	Lacks attention to detail		
___	___	Makes decisions impulsively		
___	___	Difficulty delaying what you want, having to have your needs met immediately		
___	___	Restless, fidgety		
___	___	Make comments to others without considering their impact		
___	___	Impatient, easily frustrated		
___	___	Frequent traffic violations or near accidents	AAD	5
___	___	Refusal to maintain body weight above a level most people consider healthy		
___	___	Intense fear of gaining weight or becoming fat even though underweight		
___	___	Feelings of being fat, even though underweight	AN	3
___	___	Recurrent episodes of binge eating large amounts of food		
___	___	A lack of control over eating behavior		
___	___	Engage in regular activities to purge binges, such as self-induced vomiting, laxatives, diuretics, strict dieting or strenuous exercise		
___	___	Persistent over concern with body shape and weight	BN	2
___	___	Involuntary physical movements or motor tics (such as eye blinking, shoulder shrugging, head jerking) How long have motor tics been present? _____ How often? _____ Describe: _____		
___	___	Involuntary vocal sounds or verbal tics (such as coughing, puffing, whistling, swearing) How long have motor tics been present?_____ How often?_____ Describe:_____		
___	___	Delusional or bizarre thoughts (thoughts you know others would think are false)		
___	___	Frequent feelings that someone or something is out to hurt you or discredit you		
___	___	Seeing objects, shadows or movements that are not real		
___	___	Hearing voices or sounds that are not real		
___	___	Periods of time where your thoughts or speech were disjointed or didn't make sense to you or others		
___	___	Social isolation or withdrawal		
___	___	Severely impaired ability to function at home or at work		
___	___	Peculiar behaviors		
___	___	Lack of personal hygiene or grooming		
___	___	Inappropriate mood for the situation (i.e., laughing at sad events)		
___	___	Marked lack of initiative	PsD	3
___	___	Do you snore loudly (or do others complain about your snoring)		
___	___	Have others said you stop breathing when you sleep		
___	___	Do you feel fatigued or tired during the day		SA

General Symptom Checklist

0 Never	1 Rarely	2 Occasionally	3 Frequently	4 Very Frequently	N/A Not Applicable Not Known

Self	Other	Descriptor	
___	___	Do you often feel cold when others feel fine or they are warm	
___	___	Do you often feel warm when others feel fine or they are cold	
___	___	Do you have problems with brittle or dry hair	
___	___	Do you have problems with dry skin	
___	___	Do you have problems with sweating	
___	___	Do you have problems with chronic anxiety or tension	ThyA 2

___	___	Impairment in communication as manifested by at least one of the following: (check those that apply) ☐ Delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime ☐ In individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others ☐ Repetitive use of language or odd language ☐ Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level	
___	___	Impairment in social interaction with at least two of the following (Check those that apply) ☐ Marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interactions ☐ Failure to develop peer relationships appropriate to developmental level ☐ Lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest) ☐ Lack of social or emotional reciprocity	
___	___	Repetitive patterns of behavior, interests, and activities, as manifested by at least one of the following (Check those that apply) ☐ Preoccupation with an area that is abnormal either in intensity or focus ☐ Rigid adherence to specific, nonfunctional routines or rituals ☐ Repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements) ☐ Persistent preoccupation with parts of objects	

Brain System Checklist

Please rate yourself on each of the symptoms listed below using the following scale. If possible, please have another person who knows you well (such as a spouse or roommate) rate you also to help provide a complete picture of you. Name of other person: _____

0 Never	1 Rarely	2 Occasionally	3 Frequently	4 Very Frequently	N/A Not Applicable Not Known

Self	Other	Descriptor		
___	___	Fails to give close attention to details or makes careless mistakes		
___	___	Trouble sustaining attention in routine situations (i.e. homework, chores, paperwork)		
___	___	Trouble listening		
___	___	Fails to finish things		
___	___	Poor organization for time or space (such as backpack, room, desk, paperwork)		
___	___	Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort		
___	___	Loses things		
___	___	Easily distracted		
___	___	Forgetful		
___	___	Poor planning skills		
___	___	Lack clear goals or forward thinking		
___	___	Difficulty expressing feelings		
___	___	Difficulty expressing empathy for others		
___	___	Excessive daydreaming		
___	___	Feeling bored		
___	___	Feeling apathetic or unmotivated		
___	___	Feeling tired, sluggish or slow moving		
___	___	Feeling spacey or "in a fog"		8,6,4
___	___	Fidgety, restless or trouble sitting still		
___	___	Difficulty remaining seated in situations where remaining seated is expected		
___	___	Runs about or climbs excessively in situations in which it is inappropriate		
___	___	Difficulty playing quietly		
___	___	"On the go" or acts as if "driven by a motor"		
___	___	Talks excessively		
___	___	Blurts out answers before questions have been completed		
___	___	Difficulty waiting turn		
___	___	Interrupts or intrudes on others (e.g. butts into conversations or games)		
___	___	Impulsive (saying or doing things without thinking first	<3	8,6,4
___	___	Excessive or senseless worrying		
___	___	Upset when things do not go your way		
___	___	Upset when things are out of place		
___	___	Tendency to be oppositional or argumentative		
___	___	Tendency to have repetitive negative thoughts		
___	___	Tendency toward compulsive behaviors		
___	___	Intense dislike for change		
___	___	Tendency to hold grudges		
___	___	Trouble shifting attention from subject to subject		
___	___	Trouble shifting behavior from task to task		
___	___	Difficulty seeing options in situations		
___	___	Tendency to hold on to own opinion and not listen to others		
___	___	Tendency to get locked into a course of action, whether or not it is good		
___	___	Needing to have things done a certain way or you become very upset		
___	___	Others complain that you worry too much		
___	___	Tend to say no without first thinking about question		
___	___	Tendency to predict fear	ACG	10, 7, 4

Brain System Checklist

0 Never	1 Rarely	2 Occasionally	3 Frequently	4 Very Frequently	N/A Not Applicable Not Known

Self	Other	Descriptor		
___	___	Frequent feelings of sadness		
___	___	Moodiness		
___	___	Negativity		
___	___	Low energy		
___	___	Irritability		
___	___	Decreased interest in others		
___	___	Decreased interest in things that are usually fun or pleasurable		
___	___	Feelings of hopelessness about the future		
___	___	Feelings of helplessness or powerlessness		
___	___	Feeling dissatisfied or bored		
___	___	Excessive guilt		
___	___	Suicidal feelings		
___	___	Crying spells		
___	___	Lowered interest in things usually considered fun		
___	___	Sleep changes (too much or too little)		
___	___	Appetite changes (too much or too little)		
___	___	Chronic low self-esteem		
___	___	Negative sensitivity to smells / odors	DLS	10,7,4
___	___	Frequent feelings of nervousness or anxiety		
___	___	Panic attacks		
___	___	Symptoms of heightened muscle tension (headaches, sore muscles, hand tremor)		
___	___	Periods of heart pounding, rapid heart rate or chest pain		
___	___	Periods of trouble breathing or feeling smothered		
___	___	Periods of feeling dizzy, faint or unsteady on their feet		
___	___	Periods of nausea or abdominal upset		
___	___	Periods of sweating, hot or cold flashes		
___	___	Tendency to predict the worst		
___	___	Fear of dying or doing something crazy		
___	___	Avoid places for fear of having an anxiety attack		
___	___	Conflict avoidance		
___	___	Excessive fear of being judged or scrutinized by others		
___	___	Persistent phobias		
___	___	Low motivation		
___	___	Excessive motivation		
___	___	Tics (motor or vocal)		
___	___	Poor handwriting		
___	___	Quick startle		
___	___	Tendency to freeze in anxiety provoking situations		
___	___	Lacks confidence in their abilities		
___	___	Seems shy or timid		
___	___	Easily embarrassed		
___	___	Sensitive to criticism		
___	___	Bites fingernails or picks skin	BG	10,7,4

Brain System Checklist

0 Never	1 Rarely	2 Occasionally	3 Frequently	4 Very Frequently	N/A Not Applicable Not Known

Self	Other	Descriptor	
___	___	Short fuse or periods of extreme irritability	
___	___	Periods of rage with little provocation	
___	___	Often misinterprets comments as negative when they are not	
___	___	Irritability tends to build, then explodes, then recedes, often tired after a rage	
___	___	Periods of spaciness or confusion	
___	___	Periods of panic and/or fear for no specific reason	
___	___	Visual or auditory changes, such as seeing shadows or hearing muffled sounds	
___	___	Frequent periods of déjà vu (feelings of being somewhere you have never been)	
___	___	Sensitivity or mild paranoia	
___	___	Headaches or abdominal pain of uncertain origin	
___	___	History of head injury or family history of violence or explosiveness	
___	___	Dark thoughts, may involve suicidal or homicidal thoughts	
___	___	Periods of forgetfulness or memory problems	TL 8,6,4

Kristin O. Tristao, PhD

Clinical Psychologist
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(559) 227-1977 Fax (559) 227-2698

Welcome

We would like to welcome you to our practice and we are pleased to have you as a patient. We are providing you with the following information to help you understand how this office operates. Every effort will be made to treat you with courtesy and respect. Please read this information carefully and write down any questions that you might have so that you can discuss them with our staff.

General Information

For your convenience, you may download a map to our office from our website www.FresnoMentalHealth.com. Our office is located on the south side of Warner Avenue just past TGI Fridays Restaurant.

It is your responsibility to contact your insurance company to confirm that the doctor is on your insurance panel, acquire pre-authorization for treatment, and confirm benefits for "**Outpatient Mental Health**" services before your first appointment. Be sure to state that this is for "outpatient mental health" benefits; otherwise the insurance personnel may quote you the benefits for major medical services instead.

Please arrive **15 minutes** prior to the first appointment.

You must have your paperwork completely filled out prior to you arrival, along with your insurance card(s) and any other paperwork requested by our office. **YOU WILL NOT BE SEEN BY THE DOCTOR UNLESS ALL FORMS ARE COMPLETELY FILLED OUT PRIOR TO YOUR VISIT**.

Upon arrival at the office, always check in with the receptionist so that the doctor can be informed that you have arrived.

If you have any questions, please feel free to contact our office at 559 227-1977.

Emergencies

In the event of an emergency you should call "9-1-1" to access emergency medical services. Otherwise, free evaluations can be obtained at Community Behavioral Health Center, 7171 N. Cedar Ave, Fresno, California, (559) 449-4434. For children and adolescents, call the CCAIR unit at (559) 453-3860.

If you need to contact the doctor between sessions, please leave a message with the office and your call will be returned as soon as possible. **Calls made between 5:00 p.m. and 8:00 a.m. should be of an urgent or emergency nature only.** In the event that the doctor is unavailable due to illness, vacation, or other circumstances, emergency calls will be forwarded to the on-call doctor.

Financial Policy and Code of Conduct Policy

As your mental health provider, we are committed to providing you with the best possible care. In order to achieve this goal, we need your cooperation and your full understanding of our Financial Policy and our Code of Conduct Policy.

Payment is due at the time services are rendered: This office accepts cash, personal checks, Visa and MasterCard. Returned checks are subject to a service charge of $25.00 and you may lose your privilege to write checks in our office. The patient/responsible party is responsible for payment of co-pays, coinsurance, deductibles and noncovered services at the time of service. For patients without insurance or with insurances that this office is not contracted with, payment is due in full at the time services rendered. **If you are not prepared to pay at the time of your appointment it may be necessary to reschedule your appointment.**
_____Patient/Responsible Party Initials

For patients with insurance: As a courtesy, this office will bill your insurance, if proper insurance information is provided at the time of service. The patient/responsible party will be held responsible for providing their insurance information at every visit. If your insurance requires a referral or prior authorization, it is your responsibility to assure that one has been provided to our office prior to or at the time of your scheduled appointment. It is the patient/responsible party responsibility to verify you are receiving care from a contracted provider, as we are not a provider for every insurance carrier.
_____Patient/Responsible Party Initials

Non-covered services: It is the patient/responsible party's responsibility to know their insurance plan benefits. All service charges not covered or denied by your insurance carrier are the responsibility of the patient/responsible party and payment will be due immediately or upon receipt of denial. It is the responsibility of the patient/responsible party to handle denials directly with their insurance carrier.

There are some services that are not covered by insurance that require the doctor's time and must be paid for at the time services are rendered. These include:

- Provide copies of patient records to other than treating physicians: $25.00
- Fill out forms (other than insurance related forms): $25.00 / 10 minutes
- Letters and additional reports: $25.00 / 10 minutes
- Requested telephone contacts with other than with the patient/parents: $25.00 / 10 minutes

_____Patient/Responsible Party Initials

Medicare patients: This office will bill Medicare for you. If you have a secondary insurance, we will also bill the secondary insurance as a courtesy as well. All deductibles or payment for noncovered services are due at the time services are rendered.
_____Patient/Responsible Party Initials

Missed appointments: In fairness to other patients and to the doctors, this office requires 24 hour notice for cancellation of appointments. **There will be a $100.00 no show fee assessed to your account for missed appointments or in the event you do not provide 24 hour cancellation notice.**
_____Patient/Responsible Party Initials

Past-due accounts: Accounts unpaid for more than 60 days will result in the prevention of scheduling any future non-emergency appointments until the account is paid in full or brought to a current status.

Accounts unpaid for more than 90 days will be turned over to a collection agency and may result in dismissal from the practice.
_____Patient/Responsible Party Initials

Accounts referred to collections: If your account is turned over to a collection agency, you are required to direct all correspondence to the collection agency and not our practice. You will also be responsible to pay the collection agency for any additional fees assessed, such as accrued interest fees and legal fees.
_____Patient/Responsible Party Initials

Assignment of benefits: I hereby assign and authorize payment of any insurance benefits directly to Kristin Tristao, Ph.D., PC and/or its providers. Photocopy of this agreement is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by my insurance plan(s). This assignment shall remain in effect until revoked in writing. I hereby authorize said assignee to release all necessary information to secure payment.
_____Patient/Responsible Party Initials

Medicare beneficiaries: I request that payment of any authorized Medicare benefits be made on my behalf. I assign the benefits payable to Kristin Tristao, Ph.D., PC and/or its providers.
_____Patient/Responsible Party Initials

Financial agreement: We will gladly discuss any questions relating to your account. However, we must emphasize that, as your mental health care providers, our relationship and concerns are with you and your health, not your insurance company. Not all services are covered by all insurance plans and some insurance carriers will have treatment exclusions. **All charges, including plan exclusion, are the Patient's/Responsible Party's responsibility from the time services are rendered.** We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, we encourage you to contact our office to discuss payment arrangements.
_____Patient/Responsible Party Initials

Code of Conduct Policy: Our office believes in mutual respect to and from our patients. Therefore, we have established a **Zero Tolerance Policy** against any verbal or physical abuse to our doctors and/or to our staff members. Any form of such abuse or violence will result in immediate dismissal from the practice.
_____Patient/Responsible Party Initials

I have read the above Financial Policy and Code of Conduct Policy and I fully understand and agree to the terms specified. I also acknowledge that I have been provided with a copy of the signed policy.

_____ _____
Patient or Responsible Party Signature Date

_____ _____
Print Patient Name Account Number

_____ _____
Witness Signature (Office Staff Member) Date

PATIENT AND BILLING DATA

Who referred you to this office? _____

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Sex: ☐ M ☐ F
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email: _____

What is the **patient's** relationship to the Responsible Party (Person who will pay the balance after insurance pays)?
☐ Self ☐ Daughter ☐ Son ☐ Granddaughter ☐ Grandson ☐ Other: _____

If the patient is a minor, where does the minor reside? ☐ Both Parents ☐ Mother ☐ Father
☐ Both Grandparents ☐ Grandfather ☐ Grandmother ☐ Guardian ☐ Other: _____

ACCOUNT RESPONSIBLE: (If other than the patient)

☐ Both Parents ☐ Mother ☐ Father ☐ Both Grandparents ☐ Grandfather ☐ Grandmother
☐ Guardian ☐ Other: _____

Name: _____ Date of Birth: _____
Title (Please check one): ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email: _____

Primary Care Physician: _____
Phone: _____ Fax: _____
Address: _____
City: _____ State: _____ Zip Code: _____

In case of emergency, contact: _____
Relationship of emergency contact to the **patient**: _____
Phone numbers of emergency contact: _____

Is your condition work related? ☐ Yes ☐ No

<u>If referred by an attorney or litigation is pending:</u>

Attorney: _____
Phone: _____ Fax: _____
Address: _____
City: _____ State: _____ Zip Code: _____

PRIMARY INSURANCE COMPANY:

Company: _____ Attention: _____
Mailing Address (for mental health claims): _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Ext: _____ Fax: _____

INSURED: (The person who is the policy holder) ☐ Same as Account Responsible
Name: _____ Date of Birth: _____
Title (Please check one): ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email: _____

Employer: _____ ID/SS#: _____
Group Claim #: _____ Group Name: _____

Patient's relationship to the insured: ☐ Self ☐ Daughter ☐ Son ☐ Granddaughter ☐ Grandson
☐ Other: _____

SECONDAY INSURANCE COMPANY:

Company: _____ Attention: _____
Mailing Address (for mental health claims): _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Ext: _____ Fax: _____

INSURED: (The person who is the policy holder) ☐ Same as Account Responsible
Name: _____ Date of Birth: _____
Title (Please check one): ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email: _____

Employer: _____ ID/SS#: _____
Group Claim #: _____ Group Name: _____

Patient's relationship to the insured: ☐ Self ☐ Daughter ☐ Son ☐ Granddaughter ☐ Grandson
☐ Other: _____

RELEASE OF INFORMATION:

Patient Name: _____

I hereby provide authorization for Kristin Tristao, Ph.D., PC to exchange information regarding the medical and psychological condition, and drug and alcohol treatment of the patient named above with:

_____
(Name of Patient's Personal Physician)

_____
(Name of additional Individual or Agency)

_____
(Name of additional Individual or Agency)

Signature: _____ Date: _____

CONSENT FOR TREATMENT

I hereby provide consent for Kristin Tristao, Ph.D., PC to perform a psychological or neuropsychological evaluation, and/or provide treatment to myself or my dependent.

Signature: _____Date: _____

CUSTODY ORDER VERIFICATION

Minor Patient Name: _____

In cases where the patient is a minor and the patient's parents are separated or divorced, or legal guardianship exists, we require that you specify the current Legal and Physical Custody status of your minor child.

Joint Legal Custody can be awarded separate from Joint Physical Custody. Joint Legal Custody means that either parent acting alone may consent to mental health treatment unless the order of Joint Legal Custody has language to the contrary. Orders specifically requiring shared medical decision making responsibilities (barring emergencies) will require the consent of both parents.

If you need help determining your rights to obtain and authorize mental health treatment for your child, please contact your legal representative.

Indicate below the legal and physical custody status of the minor child:

☐ Joint legal custody allowing either parent to consent to mental health treatment.
☐ Joint legal custody requiring both parents to consent to mental health treatment.
☐ Sole legal custody. (Name of person with legal custody:_____)
☐ Joint physical custody.
☐ Sole physical custody. (Name of person with physical custody: _____)
☐ There is **no record of any Custody Order** for this patient.

Your signature below certifies that you have provided correct and accurate information regarding your Custody Order and your ability to authorize mental health services for your minor child in the event of separation, divorce or legal guardianship.

_____ _____

Signature of Parent/Legal Guardian Date

NOTICE OF PRIVACY PRACTICES

We are required by law to protect the privacy of health information that may reveal your identity, and to provide you with this Notice which provides a summary the health information privacy practices of Kristin Tristao, Ph.D., PC A full copy of our current Notice will always be posted in our reception area. You will also be able to obtain your own full copy at our website www.FresnoMentalHealth.com, by calling the office at (559) 227- 1977 or asking for one at any time.

WHAT HEALTH INFORMATION IS PROTECTED

We are committed to protecting the privacy of information we gather about you while providing health-related services. Some examples of protected health information are:

- information indicating that you are a patient or receiving treatment or other health-related services from us;
- information about your health condition (such as a disease you may have);
- information about health care products or services you have received or may receive in the future; or
- information about your health care benefits under an insurance plan;

when combined with:

- demographic information (such as your name, address, or insurance status);
- unique numbers that may identify you (such as your social security number, your phone number, or your driver's license number); or
- other types of information that may identify who you are.

REQUIREMENT FOR WRITTEN AUTHORIZATION

We will obtain your written authorization before using your health information or sharing it with others outside Kristin Tristao, Ph.D., PC, except as we describe in this Notice. Uses and disclosures of health information that require your written authorization include: most uses and disclosures of psychotherapy notes, most uses and disclosures of protected health information for marketing purposes, and disclosures that constitute a sale of protected health information. Other uses and disclosures not described in this Notice or otherwise permitted by HIPAA will be made only with your written authorization. You may also initiate the transfer of your records to another person by completing a written authorization form. If you provide us with written authorization, you may revoke that written authorization at any time, except to the extent that we have already relied upon it. To revoke a written authorization, please write to Kristin Tristao, Ph.D., PC at 6700 N. 1st Street, Suite 138, Fresno, CA 93710.

YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION

We want you to know that you have the following rights to access and control your health information.

1. Right To Inspect and Copy Records.
2. Right To Amend Records.
3. Right To an Accounting of Disclosures.
4. Right To Request Additional Privacy Protections.
5. Right To Request Confidential Communications.
6. Right To Have Someone Act On Your Behalf.
7. Right To Obtain a Copy of Notices.
8. Right To File A Complaint.
9. Right To Be Notified Following a Breach of Unsecured PHI.

By signing below, I acknowledge that I have been provided a summary of the Kristin Tristao, Ph.D., PC Notice of Privacy Practices, have been informed how I may obtain a full copy, and have therefore been advised of how health

information about me may be used and disclosed by Kristin Tristao, Ph.D., PC and how I may obtain access to and control this information.

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority