

PsychArizona

Dr. Tammy Martin-Causey
Licensed Psychologist

Dr. James Schlichting
Psychology Intern

Name _____ Date _____

Date of Birth _____ Age _____ Male () Female ()

Ethnicity _____ Marital Status _____

Religious/Spiritual Orientation _____

Employment/Occupation _____

Highest Level of Education Completed _____

Phone for Emergency Contact (list relationship, ie, spouse)

Family Physician or PCP Name and Phone Number _____

Psychiatrist Name and Phone Number _____

Family Information
 People Currently Living in your Household

Name	Relationship	Age	Birthplace	Occupation or Grade Level

Family Members Not Living in Household (children, parents, siblings, etc)

Name	Relationship and Marital Status	Age	Where Living	Occupation or Grade Level

Marital History and Other Relationships

Please list the following information regarding current marriage and any divorces

Date Married	Date Separated or Divorced	Reason for Separation or Divorce

Blended Family Arrangements

Child Name and Age	Relation to you	Custody Arrangement	When in your Household

What is a strength of your current marital/partner relationship?

What is a weakness of your current marital/partner relationship?

What is the one main thing you would like to see different in your relationship?

If divorced, what did you learn about yourself through the(se) process(es)?

What if any relationships do you have that are not going well at this time?

What if any relationships do you have that are supportive and fulfilling?

Legal History

How many traffic violations have you received during the past 6 years? _____

Have you ever received a DUI? _____ If yes, list date _____

Is there a current Order of Protection for you or a family member? _____

If you've ever been convicted of a misdemeanor or felony, please list the charge and date _____

If you've ever served time in prison or been on probation or parole, please list the date and reason _____

Family Mental Health History

Has any family member been hospitalized for mental health concerns? _____

If yes, please list who, when, and for what reason _____

Do/did any family member have/had a problem with drinking alcohol or using drugs? _____

If yes, please list who, when, and for what reason _____

Have any family members killed themselves or try to kill themselves? _____

If yes, please list who, when, and what happened _____

What is your WORST memory about your family when growing up?

What is your BEST memory about your family when growing up?

Health/Mental Health Information

Have you ever seen a counselor, psychologist, psychiatrist, or other mental health professional for any mental health or drug or alcohol concerns? _____

If yes, please list who, when, and why _____

Have you ever been hospitalized for any mental health concerns? _____

If yes, please list where, when, and why _____

Do you currently have thoughts of killing yourself? _____ If yes, how often do you have these thoughts? _____

Have you ever tried to kill yourself? _____ If yes, when was this? _____

Did you receive medical help? _____ If yes, what kind of medical intervention? _____

Please check any of the following that you have experienced:

() Head Injury () Loss of Consciousness () Seizures () Convulsions

If yes, please explain _____

Have you ever had surgery? _____ If yes, please explain when, where, why,
and type _____

Height _____ Weight _____ Has your weight gone up or down by more
than 5 pds in the past 3 months? _____ If yes, how much? _____

Were you trying to lose or gain weight? _____

Are you satisfied with your weight? _____ Is there anything other than weight
you'd like to change about your body? What would it be?

Please list any CURRENT health concerns

Please list any PAST serious illnesses or health concerns

Exercise and Physical Activity

Type of Activity	How often per week

Would you describe yourself as physically active? _____ Are you more () or less () active than **3** months ago? Are you more () or less () active than **6** months ago?

Use of Substances

Substance	Current Amount	Most used in the past
Alcohol	_____ glasses per week _____ glasses per day	_____ glasses per week _____ glasses per day
Caffeine (tea, coffee, soda, energy drinks)	_____ cups per day	_____ cups per day
Tobacco	_____ cigarettes per day	_____ cigarettes per day
Marijuana	_____ per day	_____ per day
Cocaine	_____ times per day	_____ times per day
Meth	_____ times per day	_____ times per day
Diet Pills	_____ pills/doses per day	_____ pills/doses per day
Laxatives	_____ times per week	_____ times per week
Other Stimulants	_____ times per week	_____ times per week
Painkillers	_____ doses per day	_____ doses per day

Please check any symptoms that describe how you feel, think, or behave currently or during the past few weeks:

- Chronic sadness
- Crying episodes
- Hopelessness
- Difficulty concentrating
- Loss of appetite
- Overeating
- Nausea/Vomiting
- Difficulty making decisions
- Low energy/fatigue
- Agitation
- Restlessness
- Excessive worry
- Fearfulness
- Trembling/shaking
- Fear of loss of control
- Fear of dying
- Intrusive thoughts of bad memories
- Flashbacks/re-living bad experiences
- Hear voices others do not hear
- Fearful others are talking about me
- Difficulty completing tasks/distracted
- Difficulty focusing
- Tendency to act impulsively
- Not well organized
- Legal Problems
- Difficulty at work
- Racing thoughts
- Excessive spending
- Excessive gambling
- Aggressive/abusive toward others
- Thoughts of physically hurting others
- Staying up for days without sleep
- Low frustration tolerance
- Irritability
- Sleep problems
- Memory problems
- Thoughts of suicide
- Withdrawing from others
- Difficulty functioning at work
- Difficulty functioning socially
- Reduced pleasure in activities
- Panic attacks
- Fear of leaving home
- Avoidance of public places
- Avoidance of social situations
- Pounding heart/palpitations
- Shortness of breath
- Feeling detached from others/life
- Nightmares
- Easily startled/upset
- Seeing things others do not see
- Tried to kill myself
- Taking on too many tasks
- Frequent forgetfulness
- Difficult to wait my turn
- Problems with co-workers
- Problems in school growing up
- Hard to stay with a job very long
- Marital Conflict
- Multiple sexual partners
- Marital Violence
- Worried about sexual behavior
- Fearful someone is plotting against me

Please describe why you are seeking help at this time:
