PALO ALTO PSYCHOLOGY GROUP

*Please note that your privacy and security are of the utmost importance to the Palo Alto Psychology Group. All information in this form will be kept strictly confidential.

Name:

_____ _____ _____
First Middle Last

If you use or have used any other name please list here:

_____ _____ _____
First Middle Last

Maiden Name (if applicable): _____

Name (if different than above) that you prefer to be called: _____

Home Address:

_____
Street Address

_____ _____
City Zip Code

Social Security Number

_____- _____- _____

Personal Information

Age: _____ Date of birth: _____

Contact Information:

Phone (Home): _____ Okay to leave message? Yes No

Phone (Cell): _____ Okay to leave message? Yes No

Phone (Work): _____ Okay to leave message? Yes No

Email: _____

Ethnicity (circle all that apply):

Caucasian Black/African-American Hispanic South Asian Pacific Islander

Middle Eastern East Asian Southeast Asian Native American Other: _____

Reimbursement :

Would you like to receive a monthly statement that you can forward to your insurance company to request reimbursement? (circle one) Yes No

If yes, is it OK to email statements to you? Yes No, I prefer you mail it to my home address

Current Problems and Treatment History

Please briefly describe what brings you to therapy

_____

_____

Work / Education

Education and Training

Dates	School	Area of Study	Date of Graduation	Degree Earned (if applicable)

List any problems with school: _____

_____

_____

Employment

Employment status: □ Full-time □ Part-time □ homemaker □ unemployed □ retired □ disabled □ student

Current Occupation: _____

Annual Household Income:

□less than $39,999 □$40,000-$79,999 □$80,000-$99,999 □$100,000-$149,999 □$150,000-$200,000 □$200,000 +

Dates	Employer	Job Title/Duties	Reasons for Leaving

List any problems with work: _____

_____

Social / Family

Marital/Relationship Status: □ single □ married/partnered □ cohabitating □ separated □ divorced □ widowed

If married/partnered, how long? _____

Spouse/Partner's occupation: _____

Marital/Relationship History

	Spouse/Partner's Name	Your age at marriage	Spouse age at marriage	Age when divorced/widowed/ separated
FIRST				
SECOND				
THIRD				

Have you ever had a physical fight with your spouse/partner (throwing things, hitting, shoving, etc?) □ yes □ no

How do you get along with your spouse or partner?

_____

_____

Children

Name	Age	Sex	Live at Home? Yes/No	Any Issues in the relationship?

How would you describe your relationship with your children?

_____

_____

_____

Does anyone else live at home? If yes, who? _____

Please provide the following information about your family:

Relative	Name	Age	Occupation	Health Status	If living, where does s/he live?
Father					
Mother					
Stepparent(s)					
Siblings					
Other					

Where were you born?

_____

Where did you grow up?

_____

_____

Describe your parent's relationship with each other?

_____

_____

Did your parents get divorced? If yes, when? _____

Did your parents remarry? If yes, when? _____

Describe your relationship with your parents:

_____

_____

Describe your relationship with your siblings:

_____

Psychiatry / Medical

Are you presently seeing another therapist? □ yes □ no If yes, who? _____

Are you currently seeing a psychiatrist? □ yes □ no If yes, who? _____

Have you previously been in therapy before (individual, group, marital, family, psychiatrist) □ yes □ no

Age	Duration of therapy	Name of therapist /psychiatrist	Reasons for therapy	With what results?

Have you ever been hospitalized or participated in a partial hospitalization program for mental or emotional difficulties? □ yes □ no

If yes, when and why?

Dates	Age	Where hospitalized?	Reason for hospitalization

Have you ever attempted suicide? □ yes □ no If yes, when? _____

If you have not been hospitalized, has hospitalization for mental or emotional difficulties ever been recommended to you? □ yes □ no If yes, when and why?

_____

Have you ever received treatment for drug or alcohol abuse? □ yes □ no

If yes, describe the program, dates, and outcome: _____

_____

If you have not received drug or alcohol abuse treatment, has treatment ever been recommended for you? □ yes □ no

If yes, please explain: _____

Please list ALL medications you are currently taking

Date began	Medication	Dosage	Purpose	With what result?

Does anyone in your family have a history of any mental health issue? □ yes □ no If yes, who?

Depression _____

Bipolar / Manic-Depression _____

Anxiety (what type) _____

OCD _____

Schizophrenia _____

Alcohol / Drug Abuse _____

Suicide _____

Other _____

Please list any current medical problems: _____

_____

Past surgeries: _____

_____

Do you experience chronic pain issues? □ yes □ no If yes, since when? _____

Do you have any problems with sleep? □ yes □ no If yes, since when? _____

Other

Is your reason for seeking therapy related to an accident or an injury? □ yes □ no

If yes, please explain. _____

_____

Are you required by court to seek therapy? □ yes □ no

If yes, please explain. _____

_____

Are you presently in the midst of a divorce or custody battle? □ yes □ no

If yes, please explain. _____

_____

Have you ever been involved in a lawsuit? □ yes □ no

If yes, please explain. _____

_____

Have you ever been arrested for a crime? □ yes □ no

If yes, please explain. _____

_____

If there is any other information that would be helpful for me to know, please explain:

_____

_____

_____ _____

Signature Date