Belmont Psychological Services

A Psychology Corporation

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www.belmontpsych.com

Patient Information

Please Print Clearly

Full Name _____ DOB _____ Age _____

Home Address _____

STREET CITY STATE ZIP

Home Phone _____ Mobile Phone _____ Work Phone _____

SSN _____ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____

Referred by: ☐ Self ☐ Physician, if so Who? _____ ☐ Other (specify) _____

Email Address _____ May we contact you through email? ☐ Yes ☐ No

Occupation _____ Employer Name _____

Employer Address _____

STREET CITY STATE ZIP

Highest level of formal education completed? _____ Degree (s) earned _____

Responsible Party Information

Please provide information about the person financially responsible for treatment

Responsible Party Name _____ SSN _____–_____–_____

DOB _____ Relationship to Patient _____ Email _____

Home Address _____

STREET CITY STATE ZIP

Home Phone _____ Mobile Phone _____ Work Phone _____

Occupation _____ Employer Name _____

Employer Address _____

STREET CITY STATE ZIP

Emergency Contact Information

Name _____ Phone _____ Relationship to Patient _____

Name _____ Phone _____ Relationship to Patient _____

Household Members:

Name	Age	Relationship	Occupation / Grade

History

Please describe the primary symptoms for seeking therapy at this time:

_____

_____

When did the symptoms begin? _____

Have you ever been treated for mental health problems in the past? ☐ Yes ☐ No
If yes, When? _____ Where / By Who? _____
Was it helpful? ☐ Yes ☐ No Please Explain _____

Any family history of psychiatric or mental health problems? ☐ Yes ☐ No
If yes, please explain _____

Have you ever been hospitalized for any psychiatric reasons? ☐ Yes ☐ No
If yes, When? _____ Where? _____

Has you ever been prescribed medication for psychiatric or emotional difficulties in the past? ☐ Yes ☐ No
If yes, please list all medications:

Medication	Dosage	When (e.g. 06/12-02/13)	Prescribed for

Please list all **CURRENT** medications you are taking here:

Medication	Dosage	Frequency	Prescribed for

Please list any significant medical problems here: _____

_____

Please add any additional information you think would be useful _____

_____

Do you smoke?	☐ Yes ☐ No	How many per day? _____
Do you drink caffeinated beverages?	☐ Yes ☐ No	How many cups per day? _____
Do you drink alcohol?	☐ Yes ☐ No	How many drinks per week? _____
Do you exercise regularly?	☐ Yes ☐ No	How much per week? _____

Type of exercise? _____

Please check the following areas in which you are having difficulty:

☐ Aggression	☐ Distractibility	☐ Intrusive Thoughts	☐ Phobias
☐ Alcohol Use	☐ Divorce	☐ Impulsiveness	☐ Relationships
☐ Anger	☐ Drug Use	☐ Irritability	☐ Relaxation
☐ Anxiety	☐ Eating Problems	☐ Isolation	☐ Sadness
☐ Assertiveness	☐ Educational Problems	☐ Legal Matters	☐ Self-Control
☐ Being a Parent	☐ Energy	☐ Loneliness	☐ Self-Esteem
☐ Bereavement / Grief	☐ Family	☐ Making Decisions	☐ Sexual Problems
☐ Boredom	☐ Fears	☐ Marriage	☐ Shame
☐ Bowel Troubles	☐ Finances	☐ Memory	☐ Shyness
☐ Career Choices	☐ Friends	☐ My Thoughts	☐ Sleeplessness
☐ Children	☐ Guilt	☐ Nervousness	☐ Stress
☐ Chronic Pain	☐ Hallucinations	☐ Nightmare	☐ Suicidal Thoughts or Gestures
☐ Concentration	☐ Headaches	☐ Obsessions	☐ Tearfulness
☐ Compulsions	☐ Health Problems	☐ Occupational	☐ Upsetting Memories
☐ Dating Skills	☐ Health Worries	☐ Panic	☐ Unhappiness
☐ Depression	☐ Hyperactivity	☐ Perfectionism	☐ Worry

What are your goals for treatment?

1. _____

2. _____

3. _____

Signature _____ **Date** _____