



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:

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

What are your goals for treatment?

1. _____
2. _____
3. _____

Signature

Date