

CHRISTINE HALL PSYD

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PATIENT INFORMATION

PLEASE COMPLETE AND SIGN AND DATE ON LAST PAGE

LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____

SS# _____ DOB: _____ AGE: _____

MARITAL STATUS: _____

PHYSICAL ADDRESS: _____

BILLING ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ PREFERRED CONTACT NUMBER: _____

MAY WE LEAVE MESSAGES AT THIS NUMBER? Y/N

EMPLOYER: _____ OCCUPATION: _____

EMPLOYMENT ADDRESS: _____

ARE YOU: MARRIED SINGLE DIVORCED WIDOWED PARTNERED
IN A SERIOUS RELATIONSHIP

PLEASE LIST PREVIOUS MARRIAGES/SERIOUS RELATIONSHIPS:

WHAT IS YOUR PARTNER/SPOUSE'S NAME? _____

WHAT IS YOUR PARTNER/SPOUSE'S OCCUPATION? _____

PLEASE LIST THE NAMES/AGES OF YOUR CHILDREN, AND INDICATE IF THEY
ARE BIOLOGICAL, STEP, OR ADOPTED. PLEASE ALSO LIST CHILDREN IF THEY
ARE DECEASED.

EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP TO PT: _____

HOME PHONE: _____ WORK: _____ CELL: _____

REFERRED BY:

WORK / SCHOOL HISTORY:

DO YOU PRESENTLY WORK? Y/N FULL OR PART TIME?: _____

ARE YOU: A STUDENT Y/N HOMEMAKER Y/N RETIRED Y/N

IF YOU ARE A STUDENT, WHERE DO YOU ATTEND SCHOOL? _____

WHAT IS THE NATURE OF YOUR WORK? _____

HOW LONG HAVE YOU BEEN EMPLOYED WITH YOUR CURRENT EMPLOYER? _____

BRIEFLY LIST / DESCRIBE YOUR PREVIOUS JOBS: _____

WHAT IS THE HIGHEST GRADE YOU COMPLETED? _____

PLEASE LIST ANY SCHOOL DIFFICULTIES:

MEDICAL HISTORY:

DO YOU HAVE ANY MAJOR MEDICAL ILLNESSES, PREVIOUS HOSPITALIZATIONS, OR ACCIDENTS? PLEASE LIST:

HAVE YOU HAD ANY PREVIOUS PSYCHIATRIC HOSPITALIZATIONS? Y/N IF YES, WHERE / WHEN?

HAVE YOU PARTICIPATED IN THERAPY BEFORE? IF SO, WHEN? BRIEFLY DESCRIBE THE CHALLENGES ADDRESSED AT THAT TIME.

WHAT PRESCRIPTION MEDICATIONS DO YOU REGULARLY TAKE?

WHAT RECREATIONAL SUBSTANCES DO YOU USE, IF ANY, INCLUDING ALCOHOL AND TOBACCO? (INCLUDE PAST USAGE AND FREQUENCY)

_____ PRESENT / PAST _____ HOW OFTEN? _____

_____ PRESENT / PAST _____ HOW OFTEN? _____

_____ PRESENT / PAST _____ HOW OFTEN? _____

_____ PRESENT / PAST _____ HOW OFTEN? _____

DO YOU OR OTHERS CONSIDER ANY OF YOUR SUBSTANCE USE TO BE A PROBLEM? Y/N

IF YES, PLEASE DESCRIBE _____

ARE YOU HAVING DIFFICULTY SLEEPING? Y/N IF YES, DESCRIBE:

PLEASE DESCRIBE YOUR EXERCISE HABITS, INCLUDING TYPE, FREQUENCY, AND DURATION OF EACH WORKOUT:

ARE YOU HAVING DIFFICULTY WITH YOUR APPETITE OR EATING HABITS? Y/N IF YES, DESCRIBE:

BINGING RESTRICTING EATING MORE EATING LESS SIGNIFICANT WEIGHT CHANGE

DO YOU HAVE CONCERNS REGARDING YOUR SEXUAL FUNCTIONING? Y/N

PLEASE DESCRIBE:

WHAT DO YOU ENJOY DOING IN YOUR FREE TIME?

FAMILY BACKGROUND QUESTIONNAIRE

PLEASE CHECK ANY ISSUES THAT APPLY TO YOUR FAMILY:

	SELF	MOTHER	FATHER	SIBLING
ALCOHOL ABUSE				
DRUG ABUSE				
DEPRESSION				
ANXIETY				
PTSD				
BIPOLAR DISORDER				
SCHIZOPHRENIA				
ADHD				
LEARNING				
ATTEMPTED/COMPLETED SUICIDE				
PSYCHIATRIC HOSPITALIZATION				
LEGAL PROBLEMS				
FINANCIAL PROBLEMS				
VERBAL ABUSE				
PHYSICAL ABUSE				
SEXUAL ABUSE				
WEIGHT ISSUES				
ANOREXIA				
BULIMIA				
OTHER				

PLEASE LIST FAMILY MEMBERS, AGES, OCCUPATIONS, AND STATE IF THEY ARE BIOLOGICAL/STEP/ADOPTED. ALSO PLEASE STATE WHERE THEY CURRENT LIVE. IF A FAMILY MEMBER IS DECEASED, PLEASE LIST THEM AS WELL WHEN THEY PASSED.

ARE YOUR PARENTS: MARRIED DIVORCED REMARRIED

IF THEY HAVE DIVORCED AND REMARRIED, PLEASE INDICATE NUMBER OF TIMES THEY HAVE BEEN DIVORCED AND REMARRIED: _____

PLEASE USE THE SPACE BELOW TO INDICATE THE NATURE OF YOUR CURRENT CHALLENGES, INCLUDING DURATION AND HOW THEY IMPACT YOUR LIFE/FUNCTIONING, AND WHY YOU ARE PRESENTING FOR THERAPY:

HIPAA ACT AND NOTICE OF PRIVACY PRACTICES

I HAVE READ AND UNDERSTAND THE HIPAA PRIVACY FORM AND MAY REQUEST A COPY FOR MY FILES. I ALSO UNDERSTAND A COPY IS LOCATED ON DR. HALL'S WEBSITE AND MAY BE DOWNLOADED FOR MY RECORDS.

PATIENT/GUARDIAN/PARENT

DATE