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PATIENT INFORMATION FORM

Name _____ Date of Birth _____ Age _____

Insurance Carrier _____

Policy Number _____ Gender: Male _____ Female _____

Social Security#: _____

IF CLIENT IS A MINOR, THE FOLLOWING INFORMATION SHOULD PERTAIN ONLY TO PARENT/GUARDIAN

Name: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work : _____ Cell: _____

E-mail: _____ Can we contact you via e-mail? Yes _____ No _____

Single: ___ Divorced: ___ Married: ___ Widowed: ___ Separated: ___ Divorced: ___ Co-Habiting: ___

Occupation: _____ Employer: _____

Work Address: _____

Family Physician Name/Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

How did you hear about us?

- Websearch/Website
- Insurance Company
- Friend
- School Counselor _____
- Doctor _____
- Other _____

Primary Reason for Today's Visit: _____

For how long have you been experiencing this? _____

Describe any family problems which occurred while growing up relating to:

Sexual/Physical/Emotion Abuse: _____

Alcohol/Drug Abuse: _____

Have you ever been in counseling or any type of treatment in the past? (circle one) YES NO

Please explain: _____

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list: _____

MEDICAL HISTORY

Name of Primary Care Physician: _____

Physician's Address: _____ Physician's Phone: _____

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? (Circle One) YES NO

Please sign here for either answer: _____

Date of last medical evaluation: _____

Date of next appointment: _____

Medical History

Current medications being taken:

- 1) _____ Dosage/Freq _____ Start Date _____ Purpose _____
- 2) _____ Dosage/Freq _____ Start Date _____ Purpose _____
- 3) _____ Dosage/Freq _____ Start Date _____ Purpose _____
- 4) _____ Dosage/Freq _____ Start Date _____ Purpose _____

Prescribed by: _____

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you use recreational drugs? (Circle One) YES NO If no, have you used previously? (Circle One) YES NO

If yes, when did you stop? _____

Type of Drug	How much	How often
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you drink alcohol? (Circle One) YES NO If no, did you drink previously? (Circle one) YES NO

If yes, please list:

Type of Alcohol	How much	How often
_____	_____	_____
_____	_____	_____

Do you smoke cigarettes? (Circle One) YES NO

Do you use other forms of tobacco? (Circle One) YES NO If yes, what kind? _____

Describe any important medical history, chronic ailments, or other health problems you experience: _____

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments: _____

SCHOOL AND FAMILY HISTORY

Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers?

(Circle One) YES NO If yes, please explain: _____

What was the last year of school you completed? _____ If you did not complete high school, please explain:

Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers?
(Circle One) YES NO If yes, please explain: _____

What was the last year of school you completed? _____ If you did not complete high school, please explain:

Please list schools (1) currently attending, (2) last attended, (3) graduated:

(1) School(s) _____ Year(s) _____
(2) School(s) _____ Year(s) _____
(3) School(s) _____ Year(s) _____

How would you describe your current support network? (friends, relatives, etc.): Good

Please check all information which applies to your biological parents:

MOTHER	<input type="checkbox"/> living	FATHER	<input type="checkbox"/> living
	<input type="checkbox"/> deceased		<input type="checkbox"/> deceased
	<input type="checkbox"/> married		<input type="checkbox"/> married
	<input type="checkbox"/> divorced		<input type="checkbox"/> divorced
	<input type="checkbox"/> remarried _____ # of times		<input type="checkbox"/> remarried _____ # of times

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? If so, whom?

Where do your parents live? Mother _____
Father _____

Describe your relationship with your mother while growing up: _____

Currently: _____

Describe your relationship with your father while growing up: _____

Currently: _____

List first names and ages of brothers & sisters, including yourself:

Name	Age	Relationship (natural, step, half, etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMPLOYMENT HISTORY

List Most Recent Employment

Company Name: _____ Title: _____ Dates of Employment: _____

Company Name: _____ Title: _____ Dates of Employment: _____

Company Name: _____ Title: _____ Dates of Employment: _____

Company Name: _____ Title: _____ Dates of Employment: _____

MENTAL STATUS

Have you had any change in sleeping habits? (Circle One) YES NO Describe: _____

Have you had any change in eating habits? (Circle One) YES NO Describe: _____

Please check any of the following that describe how you have been feeling lately:

sad anxious depressed frightened guilty angry ashamed aggressive resentful
 worthless tearful irritable confused extreme ups/downs jealous hopeless helpless

Describe any other feelings you have had: _____

What activities or hobbies do you participate in? _____

Do you participate in regular exercise? (Circle One) YES NO Describe: _____

Describe your current working environment: _____

Have you ever **considered suicide** in connection to your **current** problem? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you ever **considered suicide** in the **past**? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you **attempted suicide recently** or in the **past**? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? (Circle One) YES NO

If yes, please explain: _____

Have you ever **considered homicide** in the **past**? (Circle One) YES NO

If yes, please explain: _____

LEVEL OF FUNCTIONING

List or describe any current impediments or problems in daily psychological, social or occupational functioning (i.e. isolation from friends/family, significant difficulty getting to work or completing daily tasks, severe financial strain, recent divorce, and problems with supervisor, etc.): My friends think I have a problem. I don't really want help. _____

THOUGHTS: Please check any of the following that apply to you:

I sometimes hear voices even though no one nearby is talking to me.

I sometimes feel that forces outside of me control me.

I sometimes feel that other people control my thoughts.

I sometimes have the same thought over and over and cannot control it.

I sometimes feel that someone is out to hurt me or do something against me.

I am sometimes unable to control my behavior. Please explain: _____

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.

Please list your therapy goals:

Reviewed by: _____

Date: _____