Courtney Linsenmeyer-O'Brien, PhD, MHR: Mental & Health History and Intake Form

Client Information as of_____(enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name_____
First Middle Last

Address_____
Street & Apt # City State Zip

Home Phone_____ Cell Phone_____ Other Phone_____

Any restrictions on contacting you?Yes No Email _____

Contact restrictions: _____

Age _____ Birth date ____/_____/_____ SS#_____ Gender: Female Male

Marital Status Single Married to: _____ Other: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext _____ Is it okay to call you at work? Yes No

Address _____

Emergency Contact _____ Relationship to Patient_____

Home Phone _____ Work Phone_____ Cell Phone _____

Name of Primary Physician _____

Referred by _____

Reason for appointment _____

Depression	Yes	No	Anxiety	Yes	No
High Blood Pressure	Yes	No	Fainting	Yes	No

Chest Pains	Yes	No	Seizures	Yes	No
Skipping/Rapid Heart Beat	Yes	No	Difficulty Walking	Yes	No
Unexpected Weight Changes	Yes	No	Numbness	Yes	No
Diabetes	Yes	No	Dizziness	Yes	No
Frequent Headaches	Yes	No	Menstrual Irregularities	Yes	No
Bone Injury	Yes	No	Heart Disease	Yes	No
Joint Injury	Yes	No	Alcoholism	Yes	No
Drug Dependency	Yes	No	Nervous Breakdown	Yes	No
Nervous Disorder	Yes	No	Insomnia	Yes	No
Drug Habit	Yes	No	Self-Destructive tendencies	Yes	No
Psychiatric Hospitalization or care	Yes	No	Seizures, Convulsions, Fainting	Yes	No
Black Outs	Yes	No	Current or Recent use of diet pills	Yes	No
Frequent Elevated Mood Changes	Yes	No	Restlessness	Yes	No
Difficulty Concentrating or Mind Going Blank	Yes	No	Muscle Tension	Yes	No
Sleep Disturbance	Yes	No	Fearful Thoughts of Future	Yes	No
Obsessive Compulsive Tendencies	Yes	No	Feelings of Detachment	Yes	No
Post-Traumatic Stress Disorder	Yes	No	Cancer	Yes	No
Have you ever attempted suicide?	Yes	No	Have you ever had thoughts of suicide?	Yes	No

1) Please list all present medications, including birth control pills, hormones, vitamins, herbal medication, diuretics, and weight loss drugs, include over-the-counter medications.

_____

_____

2) Do you have an allergic reaction to any medication? Yes No Which?_____
3) Do you react abnormally to any medication? Yes No Which?_____
4) When was your last physical exam?_____ By Whom?_____
5) Have you ever been under psychiatric care? Yes No When?_____ Why?_____
6) Have you had any recent blood work done? Yes No Where?_____
7) Is there anything else you think the doctor should know? _____

Hospitalizations (include where, when, and why):

_____

_____

8) Have you ever had any mental health counselling? Yes No

If yes, Please explain,

_____

Name of Counselor, Psychologist, or Psychiatrist_____

9) Have you ever been through a 12-step program or Mental health Rehabilitative Program?

Yes No If yes please explain

_____

10) Do you have a family history of diabetes? Yes No

11) Do you have a family history of mental illness or depression? Yes No

12) Do you have a family history of high blood pressure?

13) Have you ever been hospitalized for psychiatric issues? Yes No

14) Are you now or have you ever been on a diet? Yes No

If yes please explain, _____

15) How many meals do you usually eat per day? _____

16) How would you describe your nutrition habits? Poor Fair Good

17) Have you ever had any eating disorder or thought you may have at one time had one? Yes No

18) If yes, please explain _____

19) Do you consider yourself overweight or underweight? Yes No

If yes, please explain

_____

20) How would you characterize your life? Low stress Moderate stress High stress

21) What are your goals regarding your sessions? _____

I, the undersigned, represent that all of the information on this form is true and complete to the best of my knowledge and that I accept full financial responsibility for professional and medical services rendered.

Patient's Signature:_____Name of Minor if applicable_____Guardians Signature_____

Print name:_____ Date:_____

Payment in Full is Expected Upon Arrival

A 24 hour Cancellation Notice is Required to Avoid Charges