480-353-2499

ADULT: PATIENT – CLIENT INFORMATION

Name____ Date of Birth_________________

Address____ City_________ State_____ Zip______

Mailing Address____________________________________ City_________ State _____ Zip_____
(If different)

Phone: Primary ______________________________ Secondary ___________________________
(Best place to reach you)

Can we leave messages at either number? Yes or NO

If not, where would you like for us to leave a message? ___________________________________

Person responsible for your account ____________________________________ relationship_______

Relationship status: Single Married Partnered

Name of Spouse/Partner (parents/guardian for minor)____

Children & Ages (siblings for minor) ____

Name of primary physician ______________________________________ Phone_________________

In case of emergency notify ___________________ Relationship__________Phone_________________

Referred by____

Please explain why you are seeking help at this time:

____

____

Please explain how your problems are affecting your work and relationships, plus your general functioning:

____

____

____

____

On a 1 to 10 scale, with 1 = no distress and 10 = extreme distress, please rate your distress level now _____

Please check any health problems you have or have had:

_____lung	_____high blood pressure	_____arthritis
_____liver	_____diabetes	_____other pain
_____kidney	_____seizures	_____cancer
_____stomach/intestinal	_____head injury	_____ addictions

WAGNER
PSYCHOLOGICAL SERVICES

480-353-2499

Name____ Date of Birth ______________

Medicines you are allergic to:
____
____

Medicines you now take:
____
____
____
____

How much and what kind of exercise you get:
____
____

Height ________________ Weight ________________

SUBSTANCE USE	Average amount Past 2 months	Most ever used
Coffee	______________________	_________________
Cigarettes	______________________	_________________
Alcohol	______________________	_________________
Recreational Drugs	______________________	_________________

Please rate your level of difficulty with these problems: 0 = none 1 = mild 2 = moderate 3 = severe

___Physical health
___Chronic Pain
___ Low mood
___ Mood swings
___ Energy/motivation level
___ Memory
___ Concentration
___ Sleep
___ Sexual functioning
___Suicidal thoughts
___ Spirituality/religion
___ Marriage/relationship
___ Family conflicts

___ In-law problems
___ Job or school performance
___Friendships
___Financial problems
___ Obsessions (unwanted thoughts)
___ Nightmares
___ Thoughts of hurting someone
___ Compulsions (unwanted actions)
___ Flashbacks
___ Paranoid thoughts
___ Domestic violence (verbal)
___ Domestic violence (physical)
___ Drinking alcohol

___Using drugs
___Panic Attacks
___Phobias
___ Anxiety symptoms
  ___*sweating*
  ___ *short of breath*
  ___ *stomach upset*
  ___*dizziness*
  ___ *choking*
  ___ *racing heart*
  ___ *weakness*
  ___*dry mouth*
  ___*feeling trapped*
  ___ *panic*

For the following, please circle YES or NO and give details:

Have you had counseling or psychotherapy in the past? YES - NO ___________________________
Have you ever taken medication for your emotional or mental health? YES – NO ____________________
Have you ever been hospitalized for psychiatric problems? YES – NO __________________________
Have you ever been arrested? YES – NO ____
Is there any mental/emotional trouble, alcoholism or drug use, or suicide in your family? YES – NO
____
Have you ever had any experiences that you would consider traumatic or abusive? YES - NO
____
Have you ever tried to kill yourself or hurt yourself in any way? YES – NO ______________________
Is there any danger these days that you might hurt yourself or someone else? YES – NO ______________

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Name____Date of Birth_____________

Please describe your education:

____

Please describe the family you grew up in including your parents and names and ages of your siblings:

____
____
____
____
____

Please describe your marital or domestic partnership history. Include first names of current and past spouses, and your age at the time:

____
____
____
____
____

Please describe your support system (family you are close to, friends you talk with, etc.):

____
____

What is your current job and how do you like it?

____
____
____

Please describe your religious affiliation and practice, if any:

____
____
____

EXPLAIN ANY OTHER PERTINENT CIRCUMSTANCES:

____
____
____
____
____
____
____
____
____
____

Do you have problems with sleep? ____ If yes, please describe: ____________________________
____
____

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