Joy Piccolino, PsyD
Licensed Psychologist

Client History Form

Name: _____ Date: _____

Current living situation: _____ Marital status: _____

Briefly describe the problems or concerns that prompted you to seek therapy now: _____

How long has it been a problem?: _____

What are your goals for our work together?:_____

MENTAL HEALTH & MEDICAL HISTORY

Primary care provider/clinic: _____ Date of last physical:_____

Have you previously been treated for mental health issues? ____No ____Yes - therapy ____Yes - medication

If yes, where and when were you treated? Was it helpful?: _____

Previous hospitalizations (incl psychiatric):_____

Previous surgeries: _____

Medical/health concerns:_____

History of concussions/head injuries, dates:_____

List all current prescribed medications, dosages, and reasons for taking:_____

Symptom Checklist: Please check all symptoms that you are currently experiencing.

⬜ Intimate relationship problems ⬜ Parental stress ⬜ Family relationship problems ⬜ Work-related problems ⬜ Grief/death ⬜ Loss of relationship ⬜ Other losses ⬜ Social difficulties ⬜ School problems ⬜ Financial difficulties ⬜ Life transitions ⬜ Chronic pain ⬜ Chronic health problems ⬜ Depressed mood ⬜ Irritable mood ⬜ Fatigue ⬜ Difficulty enjoying life ⬜ Social isolation ⬜ Decreased appetite ⬜ Increased appetite ⬜ Difficulty falling asleep ⬜ Difficulty staying asleep ⬜ Early awakening ⬜ Sleeping too much ⬜ Unable to sleep ⬜ Poor concentration ⬜ Excessive guilt ⬜ Low self-esteem ⬜ Negative self-talk ⬜ Hopelessness ⬜ Moving or speaking slowly ⬜ Low sex drive ⬜ Overactive sex drive	⬜ Anxious mood ⬜ Restlessness ⬜ Worries ⬜ Racing thoughts ⬜ Panic attacks ⬜ Muscle tension ⬜ Obsessive thoughts ⬜ Repetitive rituals/behaviors ⬜ Social phobia/anxiety ⬜ Phobia of animals or objects ⬜ Trouble leaving safe environment ⬜ Experienced or witnessed traumatic event ⬜ Recurrent distressing dreams or memories related to traumatic event ⬜ Reliving traumatic experience ⬜ Avoidance of talking or thinking about traumatic event ⬜ Avoidance of people/places/ objects that remind you of traumatic event ⬜ Trouble recalling important aspects of traumatic event ⬜Changes in belief about self, others, or the world ⬜ Loss of interest in things once enjoyed before trauma ⬜ Feeling detached from others ⬜ Hypervigilance ⬜ Exaggerated startle response ⬜ Difficulty imagining the future	⬜ Suicidal thoughts ⬜ Previous suicide attempt ⬜ Self-harm behavior ⬜ Thoughts of harming others ⬜ Anger outbursts ⬜ Mood swings ⬜ Impulsive behavior ⬜ Excessive alcohol use ⬜ Drug use ⬜ Overspending ⬜ Binge eating ⬜ Purging ⬜ Restricting food intake ⬜ Obsession with Internet ⬜ Chronic feeling of emptiness ⬜ Fear of abandonment ⬜ Intense or unstable relationship ⬜ Unstable sense of self ⬜ Reactive and sudden mood shift ⬜ Visual hallucinations ⬜ Auditory hallucinations ⬜ Fear that others people are out to get you ⬜ Belief that thoughts or ideas are inserted into your head

FAMILY/SOCIAL HISTORY

Are your parents: ____alive____ deceased____ married____ divorced____other (please specify)_____

Do you have siblings? Yes / No If yes, where do you fall in birth order?_____

Family history of mental health and substance abuse:_____

Have you had legal problems? Yes / No If yes, please describe:_____

Are you involved in current litigation or a legal situation? Yes / No If yes, please describe:_____

EDUCATION/EMPLOYMENT INFORMATION

Highest grade completed:_____ Occupation:_____

Current school/employment status:_____

Military service (date and branch):_____

CAGE/CAGE-AID

Preliminary Questions:
1. Do you drink alcohol? Yes/No
2. Have you ever experimented with drugs? Yes/No

If you answered yes to either of the above questions, please answer the questions below.

1. In the last three months, have you felt you should cut down or stop drinking or using drugs? Yes/No
2. In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs? Yes/No
3. In the last three months, have you felt guilty or bad about how much you drink or use drugs? Yes/No
4. In the last three months, have you been waking up wanting to have a drink or use drugs? Yes/No

Each affirmative response earns one point. One point indicates a possible problem. Two points indicate a probable problem.

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

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