Dr. Laura Nusbaum
Clinical Psychologist
PSY 24639

CONFIDENTIAL CLIENT HISTORY AND INFORMATION

Please complete this form and bring it with you to your first session.

Biographical Information

Name: _____

Gender:_____

Address: _____

Date of birth: _____ Age: _____

Ethnicity/race: _____

Sexual orientation: _____

Relationship status: _____

Occupation: _____

Current employment: _____

What are your current concerns?: _____

_____

_____

_____

_____

How long have you had these concerns?:_____

_____

_____

Factors that might be contributing to or affecting the problem: _____

_____

_____

Referred by: _____

Emergency contact name: _____

Emergency contact phone: _____

Emergency contact's relationship to you: _____

Your home phone: _____ Is it OK to leave a message? Yes No

Your cell phone: _____ Is it OK to leave a message? Yes No

Your work phone: _____ Is it OK to leave a message? Yes No

Your Email: _____ Is it OK to email you? Yes No

Health History

How would you describe your physical health? Excellent Good Fair Poor

Do you have any significant medical problems (now or in past)?_____

_____

_____

Do you take any medications, including psychiatric medications (now or in past)?

_____

Do you have a primary care doctor? If YES, name and location: _____

_____

Mental Health History

Have you ever seen anyone for psychotherapy? No Yes

If YES, please describe nature and duration of treatment: _____

_____

_____

_____

If YES, did you receive a psychological diagnosis? Please include: _____

_____

Have you ever been hospitalized for psychiatric reasons? No Yes

Do you ever have thoughts about trying to kill yourself? No Yes

Have you ever tried to harm or kill yourself? No Yes

Are you currently under the care of a psychiatrist/psychologist? No Yes

If YES (Name/Location): _____

_____

Have you ever been in a physical fight that resulted in injury (for you or someone else)? If YES, please describe the event(s): _____

_____

_____

Have you ever had problems with substance use (alcohol, prescription medications, or illicit substances)? If YES, please describe: _____

_____

_____

What are your strengths and/or favorite qualities about yourself? _____

_____

_____

What is going well in your life these days? _____

_____

_____

What are your current goals (for self, relationships, work, other)? _____

_____

_____

_____

Which relationships are going well for you now? _____

_____

_____

Which relationships are you struggling with? _____

_____

_____

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Family History

Please list all the people in your current family:

Name	Age	Relationship to you

Please list your original family members (if different from above):

Name	Age	Relationship to you	Now lives in

Please indicate if any of your family members have experienced the following:

	Mother	Father	Siblings	Mother's family	Father's family
ADD/ADHD					
Autism Spectrum or Asperger's Disorders					
Substance Abuse					
Physical/ Sexual Abuse or Trauma					
Depression					
Anxiety Disorders					
Psychosis or Schizophrenia					
Bipolar Disorder					
Suicide					
Other:					

Please briefly describe any difficult family/childhood events (e.g. loss, divorce, abuse):_____

_____

_____

_____

How do you think these events have affected you? _____

_____

_____