NANCY IREY HOLMES, PSY D

Licensed Psychologist

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CLIENT INFORMATION

1. **IDENTIFYING INFORMATION**

Name:____ Date:________________

Address:______________________________________ City, State, Zip:________________________

Phone(s): Home_________________ Work_________________ Other _______________________

May I leave messages at Home? *Circle* Y or N At Work? Y or N Other? Y or N

Gender: M___ F___ Age:____ Birthdate:________________ SS#:____________________________

Marital Status:____ Partner (if any):_____________ Spouse/Partner SS# (Optional)____________

Education:______________________________ Spouse/Partner ____________________________

Occupation:______________________________ Employer:_________________________________

Spouse/Partner Occupation: _____________________ Spouse/Partner Work Phone:___________

Emergency Contact:______________________ Phone(s) Home:____________ Work:__________

Address:_________________________________ Relationship to Emergency Contact:__________

____________________________________ Referral Source:_______________________________

Guardian (if Under 18):________________________ Address/Phone:________________________

Family Members Names	Relationship	Age	Occupation/School	Lives with you?
____________________	_________	___	________________	Yes or No
____________________	_________	___	________________	Yes or No
____________________	_________	___	________________	Yes or No
____________________	_________	___	________________	Yes or No
____________________	_________	___	________________	Yes or No

Client's Name:____

2. **Please Describe the Primary Problem(s) for Which You are Seeking Therapy**:

____

____

Please note any of the symptoms that you are having or have had recently. Indicate N (none), L (low), M (medium) or H (high).

___Problems getting along with others
___Thoughts about hurting yourself
___Change in eating habits
___Change in sexual interest/function
___Concern about sexual orientation
___Lack of enjoyment of activities
___Feelings of extreme happiness
___Physical complaints of pain
___Thoughts about killing yourself
___ Thoughts about killing others
___Thoughts about hurting others

___Memory problems
___Change in sleep Habits
___Trouble concentrating
___Lack of energy
___Self-esteem Problems
___Trouble doing your job
___Muscle tension
___Sudden feelings of panic
___Obsessions/ compulsions
___Problems with anger
___Depression

___Extreme sadness
___Feeling helpless
___Feeling hopeless
___Hopeless
___Acting violently
___Feeling guilty
___Perfectionism
___Weight changes
___Feeling stressed
___Easily irritated
___Feeling nervous

3. **Previous Mental Health Treatment:**

A. Please tell me about your previous therapists if any: _____Check here if none.

Name | Dates of Treatment | Reason for Treatment | OutCome

____

____

____

B. Please tell me about any psychiatric hospitalizations: _____Check here if none.

____

____

____

4. **Medical Information**

Your Primary Care Physician:___________________________ Phone:______________

Other Treating Health Care
Practitioners:____ Phone:_____________

Client's Name:___________________________________

Please List Current Medical Conditions:

1. ____

2. ____

3. ____

Please List Any Allergies:

____

Current Medications:

Name	Dosage/Day	Condition Treating	Who is Perscribing?	How long Taken?

1. ____

2. ____

3. ____

Please List Others On the Back.

Indicate problems or conditions you have currently (use"C") or have had in the past (use "P")

___Muscle/Joint/Bone	___Headache	___Faintness	___Diabetes
___Appetite Problems	___Urinary	___Numbness	___Stroke
___Multiple Sclerosis	___HIV Positive	___Ulcers	___Tonsillitis
___High Cholesterol	___Kidney Disease	___Mumps	___Liver Disease
___Prostate Problem	___Measles	___Epilepsy	___Hepatitis
___Rheumatic Fever	___Scarlet Fever	___Tuberculosis	___Thyroid Fever
___Eye/Ear/Nose/Throat	___Sleep Problems	___Dizziness	___Weakness
___Chemical Dependence	___Stomach/Bowel	___Chest Pain	___Cancer
___Chicken Pox	___Asthma	___Arthritis	___Appendicitis
___Venereal Disease	___Alcoholism	___AIDS	___Genital
___Skin			

When was your last complete physical exam?____________________________

Please list any major hospitalizations, with dates and conditions treated:

1. ____

2. ____

Client's Name:________________________________

5. Substance Use History

Please indicate if you currently use or have used in the past the following substances:

	Past	Current	Amount		Past	Current	Amount
Tobacco/Cigarettes	___	___	_____	Amphetamines	___	___	_____
Alcohol	___	___	_____	Cocaine	___	___	_____
Caffeine (includes Cola, Coffee, ect.)	___	___	_____	Mushrooms	___	___	_____
Marijuana	___	___	_____	LSD	___	___	_____
Tranquilizers	___	___	_____	Psychedelics	___	___	_____
Pain Killers	___	___	_____	Sleeping Pills	___	___	_____
Over the Counter Meds	___	___	_____	Crank/Crack	___	___	_____
Prescription Meds	___	___	_____	Inhaleants (e.g. gas, glue, ect.)	___	___	_____

Other (Specify)____

Do you use or have you in the past used any of the above substances excessively? If so, please list the time period and amounts of excessive use:

____

____

Please list any past or current facilities for substance abuse treatment (specify dates):

1.____

2.____

6. Other History

A) Education

___ Less than 12 years (specify highest grade completed)________________________________

___ High School

___ College (#of years completed if no degree)

___ Master's Degree (specify)____

___ Doctoral Degree (specify)____

Did you receive special education?___Yes___No Learning Disability?___Yes___No

Client's Name:___________________________________

B) Occupation: Please list past job titles and dates

1.____

2.____

3.____

4.____

C) Family Psychiatric History

Please tell me about any family psychiatric history, including diagnoses and hospitalizations if you know them:

____

____

____

____

THANK YOU FOR TAKING YOUR TIME TO FILL THIS OUT