

NANCY IREY HOLMES, PSY D
Licensed Psychologist
 Portland: (503) 235-2466 Redmond: (541) 330-4428
www.nancyholmespsyd.com

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 L (low), M (medium) or H (high).

- | | | |
|---|---|---|
| <input type="checkbox"/> Problems getting along with others | <input type="checkbox"/> Memory problems | <input type="checkbox"/> Extreme sadness |
| <input type="checkbox"/> Thoughts about hurting yourself | <input type="checkbox"/> Change in sleep Habits | <input type="checkbox"/> Feeling helpless |
| <input type="checkbox"/> Change in eating habits | <input type="checkbox"/> Trouble concentrating | <input type="checkbox"/> Feeling hopeless |
| <input type="checkbox"/> Change in sexual interest/function | <input type="checkbox"/> Lack of energy | <input type="checkbox"/> Hopeless |
| <input type="checkbox"/> Concern about sexual orientation | <input type="checkbox"/> Self-esteem Problems | <input type="checkbox"/> Acting violently |
| <input type="checkbox"/> Lack of enjoyment of activities | <input type="checkbox"/> Trouble doing your job | <input type="checkbox"/> Feeling guilty |
| <input type="checkbox"/> Feelings of extreme happiness | <input type="checkbox"/> Muscle tension | <input type="checkbox"/> Perfectionism |
| <input type="checkbox"/> Physical complaints of pain | <input type="checkbox"/> Sudden feelings of panic | <input type="checkbox"/> Weight changes |
| <input type="checkbox"/> Thoughts about killing yourself | <input type="checkbox"/> Obsessions/ compulsions | <input type="checkbox"/> Feeling stressed |
| <input type="checkbox"/> Thoughts about killing others | <input type="checkbox"/> Problems with anger | <input type="checkbox"/> Easily irritated |
| <input type="checkbox"/> Thoughts about hurting others | <input type="checkbox"/> Depression | <input type="checkbox"/> 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 Prescribing? 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")

- | | | | |
|--|---|---------------------------------------|--|
| <input type="checkbox"/> Muscle/Joint/Bone | <input type="checkbox"/> Headache | <input type="checkbox"/> Faintness | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Appetite Problems | <input type="checkbox"/> Urinary | <input type="checkbox"/> Numbness | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Prostate Problem | <input type="checkbox"/> Measles | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Thyroid Fever |
| <input type="checkbox"/> Eye/Ear/Nose/Throat | <input type="checkbox"/> Sleep Problems | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Chemical Dependence | <input type="checkbox"/> Stomach/Bowel | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Appendicitis |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> AIDS | <input type="checkbox"/> Genital |
| <input type="checkbox"/> 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:

	<u>Past</u>	<u>Current</u>	<u>Amount</u>		<u>Past</u>	<u>Current</u>	<u>Amount</u>
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