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PSYCHOLOGICAL ASSOCIATES

Therapist's Name: _____ Date: _____

Patient Information Form

Patient's Name: _____ DOB: _____ Age:_____

Guardian Name: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Sex: ☐ Male ☐ Female Gender: ☐ Male ☐ Female ☐ Other: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow

☐ Patient's ☐ Parent's Drivers License ID #_____ SS#: _____

Employer:_____ Occupation: _____

School: _____ Student Status: ☐ Full Time ☐ Part Time

CONTACT INFO:

Cell Phone Number: _____ Okay to call: ☐ Yes ☐ No

Home Phone Number: _____ Okay to call: ☐ Yes ☐ No

Work Phone Number:_____ Okay to call: ☐ Yes ☐ No

Email:_____ Okay to email: ☐ Yes ☐ No

Person to be contacted in case of EMERGENCY:

_____	_____	_____
Name	*Relationship*	*Phone*
_____	_____	_____
Name	*Relationship*	*Phone*

Who referred you to this office?

_____	_____	_____
Name	*Relationship*	*Phone*

Primary Care Physician:

_____	_____	_____
Name	*Office Address*	*Phone*

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Insurance Information:

Will you be using insurance to cover services rendered by Karner Psychological Associates?
☐ Yes ☐ No - I will not be using insurance/I do not have insurance

1. Primary Insurance Company: _____

Policy/Member Number#_____ Group# _____

Policy Holder's Employer:_____

Policy Holder's Address: _____

Policy Holder's Phone Number: _____

Who is the policyholder? ☐ Self ☐ Spouse ☐ Parent Name: _____

Policyholder DOB: _____

2. Second Insurance Company: _____

Policy/Member Number#_____ Group# _____

Policy Holder's Employer:_____

Policy Holder's Address: _____

Policy Holder's Phone Number: _____

Who is the policyholder? ☐ Self ☐ Spouse ☐ Parent Name: _____

Policyholder DOB: _____

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Self-Report Patient History

Date: _____

Patient Name _____ DOB: _____

PRESENTING PROBLEM(S): Please describe your reasons for seeking counseling at this time.

Was there an event that made these problems surface? ☐ No ☐ Yes - if "Yes", please describe:

Have you had a traumatic life event? ☐ No ☐ Yes - if "Yes", please describe:

FAMILY HISTORY: Describe any **medical** or **psychiatric** conditions of your **parents or siblings** and any history of completed suicides by your **family members**. Please give the age/onset of psychiatric symptoms:

PSYCHIATRIC HISTORY: Include all **current/prior inpatient and outpatient treatment**, including dates, when you were in treatment; name of therapist or doctor:

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Previous treatment: Outpatient: Where / When _____

Inpatient: Where / When_____

Is another behavioral health specialist currently treating you?
☐ Yes ☐ No. If yes, who are you seeing?

_____

MEDICAL HISTORY: Include **current and previous medical problems** and the **names of the medical providers**, as well as the **dates of treatment and/or surgeries.**

List all **medications you are taking**, including dosage and what is the reason for your medication?

Medication	**Dosage**	**Frequency**	**Reason**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies to medications: ☐ Yes ☐ No - If "Yes", list medication(s) and reaction:

Allergies to food? ☐ Yes ☐ No - If "Yes", list food(s) and reaction:

Caffeine Use: ☐ Yes ☐ No Frequency: _____

Alcohol Use: ☐ Yes ☐ No Frequency: _____

Cannabis/Marijuana Use: ☐ Yes ☐ No Frequency: _____

Tobacco/Cigarette Use: ☐ Yes ☐ No Frequency: _____

Are you open to tobacco cessation programs treatment? ☐ Yes ☐ No

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SUBSTANCE ABUSE:
Have you ever abused alcohol? ☐ Yes ☐ No
Have you ever abused drugs? ☐ Yes ☐ No

If you have a history of Substance Abuse complete the following:

Substance	**Amount**	**Frequency**	**Last Used**

Are there firearms in your home? ☐ Yes ☐ No

PSYCHOSOCIAL HISTORY of PATIENT (*Adults and Children*)
Please note anything that the therapist should know about. If there is nothing to mention, just write "N/A".

Legal Issues?

Spiritual/Religious Affiliation

Educational History Completed: ☐ Elementary ☐ High School/GED ☐ College ☐ Graduate Degree

Employment History:

Cultural Influence/Concerns:

Community Resources:

Social Supports:

Military Service:

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Developmental History for Children and Adolescents

Only to be completed by a Parent or Guardian if the patient is a minor

Is the patient under 18 years of age? ☐ Yes ☐ No

Do you have any concerns about your child's prenatal development?

☐ Yes ☐ No - If yes, please describe

Do you have any concerns about your child's birth or early infancy?

☐ Yes ☐ No - If yes, please describe

Do you have any concerns about your child's development (walking, talking, toileting, etc.)?

☐ Yes ☐ No - If yes, please describe

Does your child have any physical problems? ☐ Yes ☐ No

Does your child have any psychological problems? ☐ Yes ☐ No

Does your child have any social problems? ☐ Yes ☐ No

Does your child have any intellectual problems? ☐ Yes ☐ No

Does your child have any academic problems? ☐ Yes ☐ No

Are there other areas that concern you? ☐ Yes ☐ No

Please describe any problems identified above:

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Patient Health Questionnaire

PHQ-9 – Nine Symptom Checklist

Patient Name: _____ DOB:_____ Date: _____

1. Over the <u>last two weeks</u> how often have you been bothered by any of the following problems?

	Not At All	Several Days	More Than Half the Days	Nearly Every Day
	0	**1**	**2**	**3**
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. 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.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

3. In the past two years, have you felt depressed or sad most days, even if you felt okay sometimes?

☐ Yes ☐ No

Total # Symptoms: _____ Total Score: _____

Main Office: 2280 Western Ave, Guilderland, NY 12084
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Treatment Plan

Form to be Completed by Patient

Patient's Name: _____ Date of Intake: _____

DOB: _____ Length of Visit: _____

Chief Complaints and History of Present Problems: (Check all that apply)

- ☐ Depressed Mood
- ☐ Hopelessness
- ☐ Irritability
- ☐ Decreased Energy
- ☐ Difficulty thinking clearly
- ☐ Guilt
- ☐ Grief
- ☐ Anxiousness
- ☐ Panic Attacks
- ☐ Worthlessness
- ☐ Suicidal Ideation Assessed
  - ☐ Intent ☐ Plan
- ☐ Homicidal Ideation Assessed
  - ☐Intent ☐Plan
- ☐ Difficulty Concentrating
- ☐ Temper control problem
- ☐ Obsessions/Compulsions
- ☐ Eating Disorders
- ☐ Hyperactivity
- ☐ Elevated Mood
- ☐ Dissociation
- ☐ Paranoia
- ☐ Delusions
- ☐ Hallucinations
- ☐ Emotional/Physical/Sexual Abuse Victim
- ☐ Emotional/Physical/Sexual Abuse Perpetrator
- ☐ Problems with Friends
- ☐ Problems at Work
- ☐ Problems with activities of Daily Living
- ☐ Problems at School
- ☐ Financial Problems
- ☐ Legal Problems
- ☐ Medical Problems
- ☐ Learning Problems
- ☐ Sleep Problems
- ☐ Marital Relationship problems
- ☐ Family Problems
- ☐ Sexual Problems
- ☐ Other: _____

Assessment of Life Role Functional Impairment:

Assess how current symptoms have affected the level of impairment (mild, moderate or severe) in the following categories:

	Mild 1	Moderate 2	Severe 3
Marriage Family Relationship	☐	☐	☐
Job/School Performance	☐	☐	☐
☐ Pt. On Disability ☐ Job in Jeopardy			
Friendships or Peer Relationships	☐	☐	☐
Interests or Leisure Activities	☐	☐	☐
Physical Health	☐	☐	☐
Activities of Daily Living	☐	☐	☐
Sexual Functioning	☐	☐	☐
Ability to Concentrate	☐	☐	☐
Ability to Control Temper	☐	☐	☐
Eating Habits	☐	☐	☐
☐ Weight Loss ☐Weight Gain	☐	☐	☐
Sleeping Habits			
☐ Difficulty falling asleep ☐ Staying Asleep	☐	☐	☐
☐ Early morning Awakening ☐ Sleeping Excessively	☐	☐	☐

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Treatment Plan

Form to be Completed by Patient

What would you like to achieve in therapy?

What are some of your Strengths:

What are some of your Weaknesses:

_____ _____

Patient Name Date

_____ _____

Signature of Patient or Guardian Relationship to Patient

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Safety Assessment

Date/Time: _____

_____ _____ _____
Patient Name *Date of Birth* *Age*

Do you have any current suicidal thoughts? ☐ Yes ☐ No
Do you have a plan? ☐ Yes ☐ No
Do you have intent to act on that plan? ☐ Yes ☐ No
What is/was your plan? Describe:

Do you have any current homicidal thoughts? ☐ Yes ☐ No
Against whom? _____
Do you have a plan? ☐ Yes ☐ No
Do you have intent to act on that plan? ☐ Yes ☐ No
What is/was your plan? Describe:

*** A Safety Plan was Discussed and Agreed to by Patient ☐ Yes ☐ No

Safety Plan Summary:

☐ **I understand the safety plan discussed with my therapist today, and I agree to follow the above plan of action.**

Signature of Patient and/or Guardian: _____ Date: _____

Signature of Therapist: _____ Date:_____

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