USCA PSYCHOLOGY CLINIC ADULT PATIENT INFORMATION FORM

Client Name (First and Last): _____

Date of Birth : _____ Age: _____

Gender Identity:

□ Female □ Male □ Genderqueer/Non-Binary □ Transgender □ Other: _____

Sexual Orientation:

□ Heterosexual □ Gay or Lesbian □ Bisexual □ Pansexual □ Other: _____

Racial/Ethnic Identification: *Check all that apply*

□ Black or African American □ White or Caucasian □ Asian/Asian American □ Other: _____

□ Hispanic/Latino/Spanish Origin □ American Indian or Alaska Native □ Pacific Islander or Native Hawaiian

Address: _____ City: _____

State/Province: _____ Zip/Postal Code: _____ Country: _____

Email Address: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Is it okay to leave a detailed message at the phone number(s) you provided? (Circle Yes or No)

Primary Phone Number: □ Yes □ No Secondary Phone Number: □ Yes □ No

Current employment status: □ Full-time □ Part-time □ Self-employed □ Temporary/Seasonal □ Unemployed

Occupation/job title: _____ Employer Name: _____

Emergency Contact #1 Name (First, Last): _____

Relationship to Client: _____ Phone Number: _____

Emergency Contact #2 Name (First, Last): _____

Relationship to Client: _____ Phone Number: _____

GENERAL FAMILY INFORMATION

Household Information: Please list the following information for all people the client lives with.

	Name	Age	Relationship to Client
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Health History

Please complete this medical history form. This will allow us to better serve your health needs.
The information contained here is strictly confidential.

Medical History

Do you have a history of any of the following?

Condition Name	Yes ✓	Condition Name	Yes ✓
Asthma		Cancer	
Diabetes		Cardiovascular (heart) disease	
Thyroid disease		High blood pressure	
Crohn's disease		High cholesterol	
Stomach/intestinal ulcers		Gynecologic problems	
Esophageal reflux/heartburn		Urinary/kidney problems	
Anemia		Eye problems (e.g., cataracts)	
Alzheimer's or dementia		HIV/AIDS	
Chronic pain		Sexually transmitted infection (STI)	
Migraines		Hepatitis C	
Parkinsion's Disease		Arthritis	
Seizures		Respiratory problems	
Sleep problems (e.g., insomnia)		Other (_____)	
Stroke		Other (_____)	
Traumatic Brain Injury		Other (_____)	

Surgical and Hospitalization History

Please write all surgeries you have had or any other reason you have been hospitalized and duration of stay:

	Reason you have been hospitalized	Duration of stay
1.		
2.		
3.		
4.		
5.		
6.		

Reproductive History

Please answer each of the following questions by circling an option or providing a written answer:

Age you had your first period?	_____ years old □ N/A
Are you sexually active?	□ Yes, currently □ Not currently, but in the past □ Never
Is sexual health and satisfaction something you would like to discuss with your clinician?	□ Yes □ No □ Maybe
Have you been pregnant before? □ Yes □ No	Live Births: □ Yes □ No How many? _____
Miscarriages/Losses/Abortions: □ Yes □ No	How many?_____
Have you experienced birth trauma? □ Yes □ No	If yes, please explain: _____
Are you currently experiencing any of the following?	□ Perimenopause □ Menopause □ Postmenopause □ N/A

Mental Health History

Do you or a family member have a diagnosis of any of the following? Check if you do and write their name.

Condition Name	Do you? ✓	Family Member(s)	Notes for your clinician
Depression			
Anxiety			
Eating disorder			
Autism spectrum disorder			
Bipolar disorder			
Borderline personality disorder			
Another personality disorder			
Obsessive compulsive disorder			
Substance abuse			
Schizophrenia			
Schizoaffective disorder			
Intellectual disability			
Specific Learning Disorder			
Attention deficit/hyperactivity disorder			
Other (_____)			
Other (_____)			

Trauma History

Have you experienced any of the following?

Experience Name	Yes ✓	Experience Name	Yes ✓
Childhood abuse (e.g., physical, sexual, or emotional)		Serious accident, injury, or illness	
Childhood neglect		Natural disasters or other catastrophes	
Intimate partner violence		Military combat or war-related violence	
Loss of a loved one		Other: _____	

Treatment History

Have you ever been seen for counseling or therapy? □ *Yes* □ *No* *If Yes, please describe below:*

Start date:	Duration of treatment:	Nature of problem(s) targeted:	Name of therapist:

Treatment History

Have you ever received any of the following evaluations or assessments? Check yes or no to each:			
Type of evaluation:	Received?	Date evaluated:	Name and address of evaluator(s):
Psychological	□ Yes □ No		
Educational	□ Yes □ No		
Neurological	□ Yes □ No		
Physical Therapy	□ Yes □ No		
Occupational Therapy	□ Yes □ No		
Other: _____			

Medications

Please write all medications and supplements you are currently taking for physical and psychological difficulties, as well as the duration, frequency, and your prescriber for each:

	Name of medication/supplement	Frequency and dosage (e.g., 1x day, 50mg)	Prescriber name
1.			
2.			
3.			
4.			
5.			
6.			

Daily Activities

Please answer all questions by checking the yes or no box below:

	Yes ✓	No ✓
Do you require assistance from others with daily activities?		
Have you fallen in the last 6 months?		
Have others expressed concerns about your memory?		

Please answer each of the following by checking a box below:

How often do you consume a well-balanced diet (e.g., vegetables, fruits, carbohydrates, proteins, dairy)? □ Every day □ A few times per week □ A few times per month □ Rarely □ Never
How often do you exercise? □ Every day □ A few times per week □ A few times per month □ Rarely □ Never
How often do you use nicotine products (e.g., cigarettes, vapes, chewing tobacco)? □ Every day □ A few times per week □ A few times per month □ Rarely □ Never
How often do you consume alcohol? □ Every day □ A few times per week □ A few times per month □ Rarely □ Never
How often do you consume caffeine? □ Every day □ A few times per week □ A few times per month □ Rarely □ Never

Below is a list of problems people sometimes have. Use the scale below to indicate how much each problem has distressed or bothered you during the past 7 days including today.					
0 = Not at all	1 = A little bit	2 = Moderately	3 = Quite a bit	4 = Extremely	X = Decline to answer

1. Nervousness or shakiness inside		28. Feeling afraid to travel on buses, subways, or trains	
2. Faintness or dizziness		29. Trouble getting your breath	
3. The idea that someone else can control your thoughts		30. Hot or cold spells	
4. Feeling others are to blame for most of your troubles		31. Having to avoid certain things, places, or activities because they frighten you	
5. Trouble remembering things		32. Your mind going blank	
6. Feeling easily annoyed or irritated		33. Numbness or tingling in parts of your body	
7. Pains in the heart or chest		34. The idea that you should be punished for your sins	
8. Feeling afraid in open spaces		35. Feeling hopeless about the future	
9. Thoughts of ending your life		36. Trouble concentrating	
10. Feeling that most people cannot be trusted		37. Feeling weak in parts of your body	
11. Poor appetite		38. Feeling tense of keyed up	
12. Suddenly scared for no reason		39. Thoughts of death or dying	
13. Temper outbursts that you could not control		40. Having urges to beat, injure, or harm someone	
14. Feeling lonely even when you are with people		41. Having urges to break or smash things	
15. Feeling blocked in getting things done		42. Feeling very self-conscious with others	
16. Feeling lonely		43. Feeling uneasy in crowds	
17. Feeling blue		44. Never feeling close to another person	
18. Feeling no interest in things		45. Spells of terror or panic	
19. Feeling fearful		46. Getting into frequent arguments	
20. Your feelings being easily hurt		47. Feeling nervous when you are left alone	
21. Feeling that people are unfriendly or dislike you		48. Others not giving you proper credit for your achievements	
22. Feeling inferior to others		49. Feeling so restless you couldn't sit still	
23. Nausea or upset stomach		50. Feelings of worthlessness	
24. Feeling that you are watched or talked about by others		51. Feeling that people will take advantage of you if you let them	
25. Trouble falling asleep		52. Feeling of guilt	
26. Having to check and double check what you do		53. The idea that something is wrong with your mind	
27. Difficulty making decisions		**For Internal Use Only:**	

Please describe the primary concerns that led to you coming in for services at this time and any other information you believe may help us in understanding your current difficulties: _____

_____

_____

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_____

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_____