

Shana Millstein, Ph.D.
CLINICAL PSYCHOLOGIST PSY21764



HEALTH HISTORY AND CLIENT INFORMATION
Please complete this form and bring it with you to your first session.

Name	Address	
Date of Birth	Age	Place of Birth
Marital/Partner Status	Name of Spouse/Partner	Children/Ages
Living with anyone?	Ethnicity/Race	Sexual Orientation
Education	Occupation	<input type="checkbox"/> Employed full time <input type="checkbox"/> Employed part time <input type="checkbox"/> Not employed outside the home
Current Employer	Referred by	
Emergency Contact Name	Relationship to Contact	Emergency Contact Phone

Home phone () _____ Is it OK to leave a message? No Yes

Cell phone () _____ Is it OK to leave a message? No Yes

Work phone () _____ Is it OK to leave a message? No Yes

e-mail _____ Is it OK to email you? No Yes

Health/Social History:

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

On average, how many hours do you sleep at night? _____

	No	Yes	Details
Any significant medical problems (now or in past)?			

	No	Yes	Details
Any chronic or recurring medical conditions?			
Any serious injuries, hospitalizations or surgeries?			
Any family members with psychiatric or substance abuse problems (now or in past)?			
Have you ever been hospitalized for psychiatric reasons?			
Do you currently take <u>any</u> medications (including psychiatric medications)?			
Have you taken any psychotropic (psychiatric) medications in the past?			
Have you ever experienced suicidal thoughts?			
Have you ever tried to harm or kill yourself?			
Ever been in a physical fight that resulted in injury (for you or someone else)?			
Ever had problems with substance use (alcohol, prescription medications, illicit substances)?			
Do you currently drink alcohol?			How often?
Do you currently use recreational drugs?			How often?
Any other significant medical history?			

Have you ever seen anyone for psychotherapy?

- No
- Yes (number of times/for how long?) _____

Are you currently under the care of a psychiatrist/psychologist?

- No
- Yes (Name/Location) _____

Do you have a primary care doctor (or clinic)?

- No
- Yes (Name/Location) _____

What concerns have brought you to seek therapy at this time? _____
