# **PSYCHOLOGICAL SOLUTIONS, LLC**

Background Information

Personal Data of	the Patient:					
First Name:			Middle II	nitial:		
Last Name:						
Age:		Birth	Date:			
Social Security N	umber:					
REFER	RRAL INFORMA	TION/REA	SON FOR	APPOIN	TMENT	
How were you re	ferred to Psycholo	ogical Solution	ons, LLC?			
	eague referred you erring you (only a s					
Briefly describe t appointment:	he reason for this					
Please list any tre expectations tha	-					
PREVIOUS TRE	EATMENT					
Have you, a famil LLC as your treatr	y member, relative ment Provider?	e or friend p	reviously u	sed Psycho	ological Sol	utions,
				☐ YES	∏ NO	
lf yes, under wha	t names:					
Have you or ar	nyone in your fa	amily ever	seen a m	ental he	alth prov	ider?
T YI	ES 🕅 NO					
If yes, who, wher	n, where, and why	?				

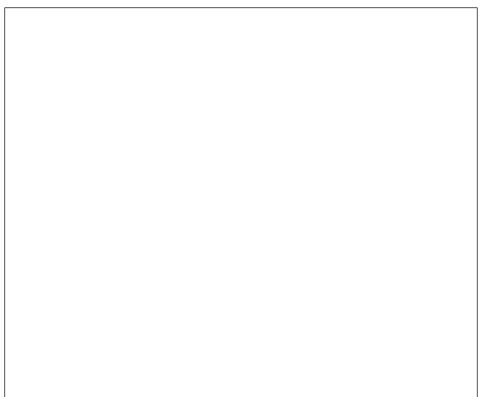
# **PSYCHOLOGICAL SOLUTIONS, LLC** Background Information (page 2)

What did you find Most Helpful/Useful in previous therapy?

What was least helpful/useful in previous therapy?

Have you ever been hospitalized for any psychiatric illness (e.g., Major Depression) or attended any Intensive Outpatient (IOP) or Partial Hospitalization Programs (PHP) or Long Term Inpatient Treatment Programs? YES NO

If yes, please tell us dates (if known); duration of treatment; and location as well as reason for referral to the program and any benefit you felt you received from it.



# **PSYCHOLOGICAL SOLUTIONS, LLC** Background Information (page 3)

#### COLLATERAL TREATMENT (OTHER TREATING PHYSICIANS)

### Who is your Primary Care Doctor (PCP)? Contact number: Name: Address and/or hospital affiliation: May we contact him or her to make them aware that we are treating you and to coordinate care? YES NO (For Women) Who is Your OB-GYN? Contact number: Name: Address and/or hospital affiliation: May we contact him or her to make them aware that we are treating you and to NO Are you presently seeing a Psychiatrist (Physician, MD OR DO)? NO If yes, Contact number: Name: Address and/or hospital affiliation May we contact him or her to make them aware that we are treating you and to coordinate care? YES NO If you are not presently seeing a psychiatrist, would you like a referral to one to evaluate you for psychotropic medication to treat your problem or consult with you on psychotropic medication?

Attorne 🔽 YES 🔽 NO

# **PSYCHOLOGICAL SOLUTIONS, LLC** Background Information (page 4)

Do you have any medical or physical problems (other than psychiatric)?

YES 🔽 NO

If yes, please describe:

Please list any medications you are taking (including psychiatric) and dosage if known. Also, list the provider who most recently prescribed this for you if known.

Do YOU or YOUR FAMILY have any significant medical problems ?	T YES	

If yes, please describe:

Do you smoke tobacco? 🦳 YES

∏ NO

If yes, please list the amount:

Please list the amounts and types of beverages with caffeine that you consume on a daily basis:

Do you or anyone in your family have any problems with alcohol?	T YES	∏ NO	

If yes, please describe:

How much alcohol do you drink in a typical week?

# **PSYCHOLOGICAL SOLUTIONS, LLC** Background Information (page 5)

Do you or anyone in your family have any problems with Drugs? $\square$ YES $\square$ NO
If yes, please describe:
BASIC BACKGROUND
What kind of work do you do?
Employer: 🗌 🗍 Full Time 🗍 Part Time
Schedule (hours and days work)
What kind of work does your spouse/partner do?
Full Time Part Time
Schedule (hours and days work)
What are the best days/times to schedule appointments for you?
What is the contact number where we can reach you, leave a message if necessary, and you can respond to us quickly (e.g., within 2 hours) should we get an appointment cancellation that fits your needs?
ls it also OK to confirm your scheduled appointments here? 🔲 YES 🗌 NO
If not, what number is better?
Are you married/partnered? YES NO If yes, how long?
Are you divorced?

# **PSYCHOLOGICAL SOLUTIONS, LLC** Background Information (page 6)

Please list the names, ages and gender of your children.

Name:	Age	Gender	Step Child / Adopted
Please list your highest leve graduate):	el of educ	ation com	pleted (for example: high school
Please list your spouse hig school graduate):	hest level	of educati	on completed (for example: high
Any Educational Programs	s started b	out not fini	shed (you and/or spouse)?

What would you say are your "top" stressors in your life now?

Thank you for taking the time to complete this. Your openness and honesty will greatly assist with helping you to achieve your treatment goals.

If there is something that was not asked here that you feel we need to know, please feel free to add it here or tell it to the therapist in your first or subsequent sessions.