SΨS SELBY PSYCHOLOGICAL SERVICES, PLLC www.doctorselby.com

Brian W. Selby, Ph.D. **Ph: (207) 299-2442** **E-mail: DoctorSelby@hushmail.com**
Christine L. B. Selby, Ph.D., CEDS **Ph: (207) 299-2552** **E-mail: DrChristineSelby@hushmail.com**
6 State Street, Suite 502
Bangor, ME 04401

The following information is requested by Selby Psychological Services (SPS) to best serve you. Please clearly print your response to each question. This will help save time in your first session. If you are unable to complete some parts, then leave them blank and you will have a chance to complete them with your psychologist. Case records are strictly confidential.

SECTION I: IDENTIFYING INFORMATION **Today's Date: _____________**

Name____ Date of Birth______________

Address____ City/State________________ Zip____________

Social Security Number___________________

Age____ Gender: F___ M___

Home Phone_________________ Work Phone__________________ E-mail _____________________

Marital Status______________________

Employment_______________________

Emergency contact_________________________________ Relationship ____________________

Home Phone________________________ Work Phone___________________

Who Referred You? ________________________

If you are Self Referred, how did you hear about Selby Psychological Services?________________________

Primary Care Provider______________________ Phone Number_____________________

Other Mental Health Provider (if any) _____________________ Phone Number _____________________

Name of Insured:________________________________ Gender _______________

Insured's Street Address:____

Patient's Relationship to Insured:__________________Insured's Birth Date___________________ ___

Insurance Carrier: ____________________________________

Employer and/or Group # of plan: _______________________

Insurance ID Number _________________________

SECTION II: DESCRIPTION OF PRESENTING PROBLEM

Please describe why you decided to seek services at SPS:

Please tell us what you want to work on or change in psychotherapy:

How long has this been a significant problem for you (Please be specific)?

How would you estimate the severity of the problem at this time? (check the box that best represents the severity)

Mild----------------------------- Moderate-------------------------------- Serious--------------------------------------- Severe

What symptoms are related to this problem? Please check **all** that apply for you **now**:

__overeating	__restless	__rapid heart rate	__compulsive behaviors
__taking drugs	__depressed mood	__sweating	__fears/phobias
__odd behavior/thoughts	__crying	__trembling or shaking	__anxiety
__recent weight gain	__difficulty concentrating	__shortness of breath	__vomiting
__recent weight loss	__low motivation	__muscle tension	__distrust
__recent appetite changes	__aggressive behavior	__outbursts of temper	__jumpy
__social withdrawal	__feelings of worthlessness	__nightmares	__restricting food
__suicidal thinking	__impulsive/risky behavior	__easily distracted	__fatigue/loss of energy
__dizziness	__sleeping too much	__decreased need for sleep	__obsessions
__difficulty falling asleep	__problems at work/school	__financial problems	__relationship problems
__difficulty staying asleep	__housing problems	__drinking alcohol	__other: ____________
__ experienced a traumatic event	__chronic pain		

If applicable, please describe any incidents or problems that may have contributed to this problem (e.g., problem with work or school, relationship ending, past trauma, etc.):

In the past, what has been helpful to you in dealing with this problem?

SECTION III: MEDICAL HISTORY

Please list any significant past or current **health, medical, or psychiatric issues** (including anything resulting in hospitalizations).

Dates /Problem/ Treatment/ Were you hospitalized (Y/N)

Have you **ever had treatment by**, or are you **currently seeing**, a psychiatrist, psychologist, therapist, or counselor?

Yes ___ No ___

Problem/ Where /When/ Therapist/ Helpful (Y/N)

Have you ever been given a mental health diagnosis in the past from a mental health professional? Yes____ No____

If yes, as you understand it, what is/was that diagnosis? ____

SECTION IV: MEDICATIONS AND SUBSTANCES USED If applicable, please list all medications you are now taking or have taken in the past three months, **including birth control pills, vitamins, herbs and supplements**.

Medications/Dosage/Prescribing Provider/Length of prescription/Helpful (Y/N)

Other Drugs/Substances Used (Illicit or other) /How long have you been using this substance?

Consider a typical week during the **past month**. Please fill in a number for each day of the week indicating the typical number of alcoholic drinks you usually consume on that day and the typical number of hours you usually drink on that day. ***Please use the key to denote which number represents number of drinks and number of hours.***

Su	M	T	W	T	F	Sa
# = Number of Drinks						
Hrs = Number of hours spend drinking						

1 Drink = 12 oz. beer / 10 oz. microbrew / 8 oz. malt liquor /4 oz. of wine / 1 oz. of hard alcohol (regular shot glass)

If applicable how many cigarettes smoked per day? ___________________________

How many caffeinated beverages do you drink per day? Of what type?____________________________________

Please complete this form and bring it with you to your first appointment, email it to your psychologist, or send it via postal mail.