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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 _____

Insured's Social Security #: _____

Insurance Carrier: _____

Employer and/or Group # of plan: _____

Insurance ID (if different from Social Security 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? (Place "X" on the line below)

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

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

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> overeating | <input type="checkbox"/> restless | <input type="checkbox"/> rapid heart rate | <input type="checkbox"/> compulsive behaviors |
| <input type="checkbox"/> taking drugs | <input type="checkbox"/> depressed mood | <input type="checkbox"/> sweating | <input type="checkbox"/> fears/phobias |
| <input type="checkbox"/> odd behavior/thoughts | <input type="checkbox"/> crying | <input type="checkbox"/> trembling or shaking | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> recent weight gain | <input type="checkbox"/> difficulty concentrating | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> vomiting |
| <input type="checkbox"/> recent weight loss | <input type="checkbox"/> low motivation | <input type="checkbox"/> muscle tension | <input type="checkbox"/> distrust |
| <input type="checkbox"/> recent appetite changes | <input type="checkbox"/> aggressive behavior | <input type="checkbox"/> outbursts of temper | <input type="checkbox"/> jumpy |
| <input type="checkbox"/> social withdrawal | <input type="checkbox"/> feelings of worthlessness | <input type="checkbox"/> nightmares | <input type="checkbox"/> restricting food |
| <input type="checkbox"/> suicidal thinking | <input type="checkbox"/> impulsive/risky behavior | <input type="checkbox"/> easily distracted | <input type="checkbox"/> fatigue/loss of energy |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> sleeping too much | <input type="checkbox"/> decreased need for sleep | <input type="checkbox"/> obsessions |
| <input type="checkbox"/> difficulty falling asleep | <input type="checkbox"/> problems at work/school | <input type="checkbox"/> financial problems | <input type="checkbox"/> relationship problems |
| <input type="checkbox"/> difficulty staying asleep | <input type="checkbox"/> housing problems | <input type="checkbox"/> drinking alcohol | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> experienced a traumatic event | <input type="checkbox"/> 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? _____