Robert Hirsch, Ph.D.

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GENERAL INFORMATION

Name: _____ Age: _____ Birthdate: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Social Security: _____

Occupation: _____ Employer: _____

Relationship Status: _____Single _____Couple _____Married/Domestic Partner

Name Of Partner/Spouse: _____

Emergency Contact: _____ Phone: _____

Relation Of Contact: _____ Referred By: _____

Insurance Co: _____ Id. Number: _____

Insurance Co. Address: _____

I Understand That All Appointments Must Be Cancelled At Least 24 Hours In Advance Or I Will Be Charged For The Missed Session. Charges For Cancellations Or Missed Appointments Cannot Be Billed To Insurance Carriers. My Signature Below Indicates My Permission To Bill My Insurance Carrier And Provide Them With The Relevant Information For Such Purposes.

_____ _____

Client Signature Date

BIOPSYCHOSOCIAL HISTORY

What Is The Reason(S) For Beginning Therapy? _____

_____

_____

When Did The Problem(S) Begin?_____

Current Symptom Checklist (Rate Intensity Of Symptoms That Are Currently Present)

	Mild	Moderate	Severe		Mild	Moderate	Severe
Depressed Mood	_____	_____	_____	Anxiety/Worry	_____	_____	_____
Appetite Disturbance	_____	_____	_____	Panic Attacks	_____	_____	_____
Sleep Disturbance	_____	_____	_____	Phobias/Fears	_____	_____	_____
Fatigue/Low Energy	_____	_____	_____	Avoiding People	_____	_____	_____
Impaired Concentration	_____	_____	_____	Mood Changes	_____	_____	_____
Impaired Memory	_____	_____	_____	Agitation	_____	_____	_____
Obsessive Thinking	_____	_____	_____	Hopelessness	_____	_____	_____
Compulsive Behaviors	_____	_____	_____	Substance Abuse	_____	_____	_____
Anger/Irritability	_____	_____	_____	Poor Functioning	_____	_____	_____
Sexual Dysfunction	_____	_____	_____	Suicidal Thoughts	_____	_____	_____
Lack Of Motivation	_____	_____	_____	Loss Of Pleasure	_____	_____	_____

Current Stressors Checklist (Rate Intensity Of Current Stress, If Any, In Each Of These Areas)

	Mild	Moderate	Severe		Mild	Moderate	Severe
Employment	_____	_____	_____	Finances	_____	_____	_____
Primary Relationship	_____	_____	_____	Family	_____	_____	_____
Friendships	_____	_____	_____	Health	_____	_____	_____
Legal Issues	_____	_____	_____	Housing	_____	_____	_____
Dating	_____	_____	_____	Aging	_____	_____	_____
Communication	_____	_____	_____	Discrimination	_____	_____	_____
Learning	_____	_____	_____	Identity	_____	_____	_____

Do You Drink Alcohol? ___Yes ___No (If Yes, Please Indicate Frequency And Quantities)

_____

(Note: We Will Discuss The Use Of Other Substances Separately, And I Don't Request That You Indicate This In Writing – For Your Own Protection.)

MEDICAL HISTORY

Please List Any Current Health Conditions For Which You Are Experiencing Symptoms And/Or Receiving Treatment: _____

_____

Please List All Current Medications: _____

_____

Please List Any Previous Health Conditions (E.G. Major Surgeries, Serious Injuries): _____

_____

HISTORY OF MENTAL HEALTH TREATMENT

Have You Been In Psychotherapy Before? ___Yes ___No (If Yes, Please Indicate Timeframes And Primary Focus Of Treatment) _____

_____

_____

Have You Been In Substance Abuse Treatment? ___Yes ___No (If Yes, Please Indicate Timeframes And Primary Focus Of Treatment) _____

_____

_____

Has Any Member Of You Biological Family Of Origin (Not Including Adoptive Family Members) Been Diagnosed Or Treated For A Mental Or Substance Disorder? ___Yes___No
(If Yes, Please Indicate Relation And Details) _____

_____

_____

GOALS

What Changes Or Goals Would You Like To Experience From Therapy? _____

_____

_____