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Psychological Services of Scottsdale (PSOS) PLC

PATIENT HISTORY AND INFORMATION

Today's Date _____ Referred By _____

Name _____ Date of birth _____ Age _____

Relationship Status: Single Married Separated Divorced Widowed

Number of Children/Ages: _____ N/A

Occupation: _____ Are you currently working? Y N

Address: _____

City/Zip Code: _____

Phone (_____) _____ Can our office leave a message? YES NO

Name of person you give permission to help in scheduling your appointments: _____

How long have you been dealing with your medical condition/pain? _____

Why Are You Currently Seeking Treatment?

_____

_____

_____

_____

Previous/Current Counseling or Psychiatric Treatment:

Name of Therapist/Clinic/Hospital	Inpatient/Outpatient	Dates
_____	_____	_____
_____	_____	_____

Current Pain / Psychiatric Medications:

Medication Name	Dosage (if known)	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do You Have a History of Alcohol or Substance Abuse? YES NO

If Yes, Did You Receive Treatment? YES NO

Have You Ever Been Diagnosed With a Psychiatric Illness? YES NO

If Yes, What Was the Diagnosis/Diagnoses? _____

How would you describe your ability to cope with your life in general?

_____

How would you describe your ability to cope with your medical condition/pain?

_____

Do you expect to have some limitations related to this condition for the rest of your life?

N/A Yes I'm not sure yet No, I believe I can be symptom free

What Do You Hope To Accomplish in Treatment?

_____

_____

_____

_____