Mark Ettensohn, Psy.D.

Licensed Clinical Psychologist | PSY 25461

PATIENT INFORMATION FORM

Name ____ Date of Birth ____/____/____

Age _______ Relationship Status ____________________

Home address (city, state, zip code):

____

____

Please list your phone numbers and check next to the number(s) where you prefer to be contacted:

Home (_____)______________________ Message may be left at this number [ ]Yes [ ] No

Work (_____)______________________ Message may be left at this number [ ]Yes [ ] No

Cell (_____)______________________ Message may be left at this number [ ]Yes [ ] No

Email Address ____

Have you previously been seen for mental health treatment? [ ]Yes [ ] No

If yes, please list the provider(s), treatment(s), duration(s):

____

____

____

Have you ever been hospitalized for a mental health issue? [ ]Yes [ ] No

If yes, please briefly describe:

____

____

If yes, was the hospitalization voluntary? [ ]Yes [ ] No

Have you ever been admitted to residential or intensive outpatient treatment? [ ]Yes [ ] No

If yes, please briefly describe:

____

____

How were you referred to my practice?

____

Employment Information:

Employer:______________________________ [ ]Full Time [ ]Part Time # of Hours/week______

Please complete the following brief assessments to the best of your ability and according to your level of comfort. All information provided will remain strictly confidential within the bounds of the law.

Please check any symptoms you have experienced in the last 6 months:

[ ] accelerated heart rate
[ ] change in appetite
[ ] change in mood
[ ] changes in sleep patterns
[ ] chest pain
[ ] cutting, punching, or burning myself
[ ] decrease in sexual interest
[ ] difficulties concentrating
[ ] feelings of restlessness
[ ] feelings of worthlessness
[ ] increase in energy
[ ] irritability
[ ] loss of energy
[ ] loss of interest in activities
[ ] nausea
[ ] nightmares/night terrors
[ ] paranoid thoughts
[ ] problems with attention, motivation, memory
[ ] recurrent or excessive anxiety or worry
[ ] recurrent thoughts of death
[ ] recurrent thoughts of harming others
[ ] recurrent thoughts or wanting to commit suicide
[ ] seeing or hearing things that others do not
[ ] shortness of breath
[ ] significant weight loss/gain
[ ] substance abuse (alcohol or drugs)
[ ] sweating
[ ] trembling or shaking

Please indicate the responses that best apply to you:

Have you ever thought about or attempted to kill yourself?

[ ] Never.
[ ] It was just a brief passing thought.
[ ] I have had a plan at least once to kill myself but did not try to do it.
[ ] I have had a plan at least once to kill myself and really wanted to die.
[ ] I have attempted to kill myself, and really wanted to die.

How often have you thought about killing yourself in the past year?

Never = [ ] [ ] [ ] [ ] [ ] = Frequently

In the past year, have you had an internal debate/argument (in your head) about whether to live or die?

Never = [ ] [ ] [ ] [ ] [ ] = Frequently

Right now, how much do you wish to live?

Not at all = [ ] [ ] [ ] [ ] [ ] = Very much

Right now, how much do you wish to die?

Not at all = [ ] [ ] [ ] [ ] [ ] = Very much

How likely is it that you will attempt suicide someday?

Not at all = [ ] [ ] [ ] [ ] [ ] = Very likely

Please indicate your use of the following substances:

	Current Use		Past Use	
	# of days per week	Amount per day	# of days per week	Amount per day
Alcohol: ____________	1 2 3 4 5 6 7	____________	1 2 3 4 5 6 7	____________
Drugs: ____________	1 2 3 4 5 6 7	____________	1 2 3 4 5 6 7	____________
____________	1 2 3 4 5 6 7	____________	1 2 3 4 5 6 7	____________
____________	1 2 3 4 5 6 7	____________	1 2 3 4 5 6 7	____________
Tobacco: ____________	1 2 3 4 5 6 7	____________	1 2 3 4 5 6 7	____________
Other: ____________	1 2 3 4 5 6 7	____________	1 2 3 4 5 6 7	____________

Do you feel that you have a problem with alcohol or substance use? [ ]Yes [ ] No [ ] Maybe

When was the last time you had more than 4 drinks on 1 occasion? ____________________________________

Have you ever experienced a blackout from drinking too much alcohol? [ ]Yes [ ] No

If yes, how many? ______________ Date of last blackout: _________________________

Have you ever tried to stop or reduce your alcohol or substance abuse? [ ]Yes [ ] No

Were you successful? [ ]Yes [ ] No

Do other people consider your alcohol or substance use a problem? [ ]Yes [ ] No

<u>Please read each description and CIRCLE the letter corresponding to the relationship style that best describes you or is closest to the way you generally are in your close relationships.</u>

A. It is easy for me to become emotionally close to others. I am comfortable depending on them and having them depend on me. I don't worry about being alone or having others not accept me.

B. I am uncomfortable getting close to others. I want emotionally close relationships, but I find it difficult to trust others completely, or to depend on them. I worry that I will be hurt if I allow myself to become too close to others.

C. I want to be completely emotionally intimate with others, but I often find that others are reluctant to get as close as I would like. I am uncomfortable being without close relationships, but I sometimes worry that others don't value me as much as I value them.

D. I am comfortable without close emotional relationships. It is very important to me to feel independent and self-sufficient, and I prefer not to depend on others or have others depend on me.

Please rate each of the previous relationship styles according to the extent to which you think each description corresponds to you.

	Not at all like me		Somewhat like me			Very much like me	
Style A.	1	2	3	4	5	6	7
Style B.	1	2	3	4	5	6	7
Style C.	1	2	3	4	5	6	7
Style D.	1	2	3	4	5	6	7

Trauma History:

Have you ever been the victim of a crime?

Have you ever experienced physical trauma (e.g. auto accident, head trauma, assault)?

Have you ever experienced emotional trauma (e.g. victim of crime, abuse, loss of loved one)?

Have you ever experienced sexual trauma (e.g. molestation, harassment, assault)?

Legal History:

Have you ever been arrested for a crime? [ ]Yes [ ] No

If yes, please briefly describe:

Were you convicted? [ ]Yes [ ] No

Family History:

Are your parents married / separated / divorced / remarried?

If divorced, how old were you at the time?

With whom did you live as a child?

Did you experience any major moves, transitions, or losses during childhood or adolescence?

Is there a history of mental illness or substance abuse in your family? If yes, please briefly describe:

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Medical History:

Do you have any major medical conditions of which I should be aware?

Are you currently under the care of a physician? [ ]Yes [ ] No

Physician Name:______________________________________

Contact Information (I will not contact without your written authorization):

____

____

Please list any medications you are currently taking:

Medication	Dosage	Purpose
__________________________	_____________	_________________________________
__________________________	_____________	_________________________________
__________________________	_____________	_________________________________
__________________________	_____________	_________________________________
__________________________	_____________	_________________________________

Is there anything else you would like me to know as your therapist?

Date: ______________ Signature: ____________________________________