Nancy L. Sack, Ph.D.

PATIENT CLINICAL, PERSONAL, AND BACKGROUND INFORMATION

Nancy L. Sack, Ph.D. • (334) 590-8492

Patient Name: _____ _____ **Today's Date:** _____

I look forward to getting to know you. I understand that revealing private and sensitive information on a form is impersonal and that you might prefer to reveal some of this information with me directly. I understand that completely, so please feel free to reveal some of this information in person. Filling out this form helps me understand you more deeply and advances the therapy process. *Please note that this form has 9 pages for you to fill out.* Thank you for taking your time to fill this out and for allowing me to get to know you.

Briefly describe the symptom/problem(s) for which you are seeking assistance, including for how long.

Have you ever before been treated by a psychologist, psychiatrist, or counselor? ◯ Yes ◯ No

If yes, please note when, how long, by whom, and for what symptoms/conditions.

What was most helpful in your prior psychotherapy/counseling.

What was least helpful in your prior psychotherapy/counseling.

Have you ever been hospitalized for <u>mental health</u> symptoms? ◯ Yes ◯ No

If so, please note when, where, and for what symptoms.

Continued on the next page

Check any of the following that often apply to you.

- ☐ Trouble getting to sleep
- ☐ Waking during the night
- ☐ Waking earlier than you want most days
- ☐ Poor sleep
- ☐ Excessive sleep
- ☐ Nightmares
- ☐ Fatigue
- ☐ Poor concentration
- ☐ Poor memory
- ☐ Phobias
- ☐ Anxiety
- ☐ Panic Attacks
- ☐ Panic
- ☐ Perfectionistic
- ☐ Control issues
- ☐ Flashbacks
- ☐ Losing time
- ☐ Agitation
- ☐ Manic
- ☐ Can't slow down
- ☐ Irritability
- ☐ Social isolation
- ☐ Social withdrawal
- ☐ Family problems
- ☐ Apathy/Poor motivation
- ☐ Tearful
- ☐ Anger problems
- ☐ Repeated thoughts
- ☐ Racing thoughts
- ☐ Mood swings
- ☐ Self hate
- ☐ Want to die
- ☐ Want to hurt someone
- ☐ Weight loss
- ☐ Weight gain
- ☐ Paranoid
- ☐ Hearing voices
- ☐ Impatient
- ☐ Poor impulse control
- ☐ Passive
- ☐ Aggressive
- ☐ Defensive
- ☐ Defiant
- ☐ Disruptive behavior
- ☐ Oppositional
- ☐ Rebellious
- ☐ Hyperactive
- ☐ Cruel to animals
- ☐ Binging
- ☐ Purging
- ☐ Loss of appetite
- ☐ Cutting or otherwise hurting yourself
- ☐ Procrastination
- ☐ Guilt
- ☐ Can't make decisions
- ☐ Manipulative

Check any of the following that often apply to you. I picture myself:

- ☐ Being hurt
- ☐ Losing control
- ☐ Hurting others
- ☐ Not coping
- ☐ Being followed
- ☐ Being in charge
- ☐ Being laughed at
- ☐ Succeeding
- ☐ Being talked about
- ☐ Failing
- ☐ Well loved
- ☐ Socially Successful

Medications for <u>mental health</u> you are currently taking or have taken in the past, if any. ○ None

Medication	Symptoms Prescribed For	How long used	Currently in use

Continued on the next page

List who in your family has been diagnosed and/or received treatment for psychological/psychiatric symptoms (parent, grandparent, sibling, children, other relative)

Family Member	Diagnosis/Symptoms	Treatment/Medication

Check any of the following that often apply to you.

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting spells
- ☐ Blackouts
- ☐ Stomach trouble
- ☐ Bowel disturbances
- ☐ Diarrhea
- ☐ Constipation
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Tics
- ☐ Skin problems
- ☐ Hearing problems
- ☐ Tension
- ☐ Unable to relax
- ☐ Palpitations
- ☐ Chest pain
- ☐ Don't like to be touched
- ☐ Sinus distress
- ☐ Chronic pain (Specify nature of pain)

List current, recurring, or past <u>medical health</u> concerns, treatments currently receiving, and treatment provider.

Medication for <u>physical health</u> you are currently taking, if any. ○ None

Medication	Condition Prescribed For	Used For How Long

List any history of major surgery (including approximate year or age at the time of surgery)

Continued on the next page

Please list any Over the Counter Medications, sleep aids, vitamins, minerals, herbs and/or dietary supplements currently used ◯ None

Agent	Condition/Problem Used For	Used For How Long

Have you ever had a head injury which resulted in loss of consciousness or which may have been associated with a concussion or with problems in thinking, emotion, or behavior? ◯ Yes ◯ No

Have you ever fainted or had a seizure? ◯ Yes ◯ No

Do you have any medication allergies or sensitivities? ◯ Yes ◯ No
If yes, please specify

Do you have any food sensitivities? ◯ Yes ◯ No
If yes, please specify

Do you have any seasonal allergies? ◯ Yes ◯ No
If yes, please specify

Do you regularly engage in physical exercise? ◯ Yes ◯ No
If yes, please specify

Alcohol and Drug Use, please indicate all that apply. ◯ None

	Age first used	Age last used	Frequency and amount of use
☐ Beer			
☐ Liquor			
☐ Wine			
☐ Marijuana			
☐ Cocaine/crack			
☐ Methamphetamine/ Crystal			
☐ Heroin			
☐ Barbiturates (downers)			
☐ PCP, LSD (hallucinogens)			
☐ Tobacco (in any form)			
☐ Other			

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Have you ever felt like you should cut down on your use of alcohol or drugs? ◯ Yes ◯ No

Has a friend or relative expressed concerns about your use of alcohol or drugs? ◯ Yes ◯ No

Have you ever felt guilty or worried about your use of alcohol or drugs? ◯ Yes ◯ No

Have you ever had to take a drink or use a drug the next day to steady your nerves? ◯ Yes ◯ No

Have you ever received outpatient alcohol, drug, or detoxification treatment? ◯ Yes ◯ No

Have you ever received inpatient alcohol, drug, or detoxification treatment? ◯ Yes ◯ No

Are you a recovering alcoholic or a recovering drug addict? ◯ Yes ◯ No

Does anyone in your family have or has had problems with alcohol or drugs? ◯ Yes ◯ No
If so, who, what substance, and problems caused.

Current frequency of use of caffeine. ◯ Very Often ◯ Frequently ◯ Rarely ◯ Never

Relationship status:
◯ Single ◯ Married ◯ Committed Relationship ◯ Legally Separated
◯ Divorced ◯ Widowed ◯ Polyamorous ◯ Other

What is the length of any current intimate relationship. _

Please indicate the quality of your intimate relationship.
☐ Excellent ☐ Good ☐ Needs Improvement ☐ Poor ☐ Possibly ending relationship

Do you have children/stepchildren? ◯ Yes ◯ No

Child's Name	Age	Stepchild	Adopted
		☐	☐
		☐	☐
		☐	☐
		☐	☐

How many people live in your current household? Please list them and your relationship to them.

Continued on the next page

Has religion or spirituality played an important role in your life, in the past or currently?
◯ Yes ◯ No If yes, what do you think is important for me to be aware of.

Has race, ethnicity, or culture played an important role in your life?
◯ Yes ◯ No If yes, what do you think is important for me to be aware of.

Place of Birth **Where were your raised**

Name of parents: Mother Father

Marital status of parents ◯ Living Together ◯ Not Living Together ◯ Never Together

If not together, what was your age at the time of separation?

Were you adopted or separated from your parents during childhood? ◯ Yes ◯ No

Stepfather's Name Stepmother's Name

Sibling's Name	Age	Half Sib	Step Sib
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

Have you ever served in the military? ◯ Yes ◯ No If yes: Date of service
Type of discharge Combat experience
Highest rank

Highest school degree you earned **Are you in school now** ◯ Yes ◯ No

Are you currently involved in a legal case/proceedings or planning on legal proceedings? ◯ Yes ◯ No
If yes, please describe.

Continued on the next page

Please indicate all legal actions or proceeding you currently are OR historically have been a part of.

☐ None ☐ Arrest for assault ☐ Arrest for other ☐ DUI (how many)
☐ Prison ☐ Domestic Violence ☐ Divorce/custody ☐ Restraining/protective order
☐ Child Protective Services ☐ Disability Claim
☐ Other (describe)

Have you had a loss (death, divorce, significant situational loss, other) in the past 24 months.

◯ Yes ◯ No If yes, please describe.

Did you experience any losses (as above) during childhood or adolescence?

◯ Yes ◯ No If yes, please list the nature of your loss and your age at the time of the loss.

Check all that apply to your life history.

☐ None ☐ Primary care givers used too much alcohol or drugs ☐ Raped ☐ Assaulted
☐ Sexually molested (age and by whom)
☐ Physically or verbally abused (age and by whom)

Have you ever made a suicide attempt? ◯ Yes ◯ No

If yes, most recent date

If yes, how many times, age, method, treatment for.

Do you own or have access to a firearm? ◯ Yes ◯ No

Have you relocated or changed jobs within the past 24 months? ◯ Yes ◯ No

Have you experienced physical, emotional, or sexual trauma or abuse? ◯ Yes ◯ No

If yes, is this something we can talk more about in person? ◯ Yes ◯ No

How have you gotten through times of hardship or stress in the past?

Continued on the next page

What is your most often used coping mechanism?

Check any of the following that often apply to you.

- ☐ Incompetent
- ☐ Unattractive
- ☐ Stupid
- ☐ Undesirable
- ☐ Crazy
- ☐ Evil
- ☐ Deviant
- ☐ Life is empty
- ☐ Failing
- ☐ Worthless
- ☐ Life is a waste
- ☐ A nobody
- ☐ Unlovable
- ☐ There is nothing to look forward to
- ☐ Confused
- ☐ Full of regrets
- ☐ Useless
- ☐ Can't do anything right
- ☐ Morally degenerate

- ☐ Intelligent
- ☐ Confident
- ☐ Ambitious
- ☐ Sensitive
- ☐ Trustworthy
- ☐ Hard working
- ☐ Attractive
- ☐ Persevering
- ☐ Good sense of humor
- ☐ Life is full of interest

Select the number that most accurately reflects your opinion:

Trait	Strongly Agree (5)	Agree (4)	Neutral (3)	Disagree (2)	Strongly Disagree (1)
I should not make mistakes	○	○	○	○	○
I should be good at everything I do	○	○	○	○	○
When I do not know, I should pretend that I do	○	○	○	○	○
I should not disclose personal information	○	○	○	○	○
My life is controlled by outside force	○	○	○	○	○
Other people are happier than I am	○	○	○	○	○
It is very important to please other people	○	○	○	○	○
Play it safe, don't take any risks	○	○	○	○	○
If I ignore my problems, they will disappear	○	○	○	○	○
It is my responsibility to make other people happy	○	○	○	○	○
I should strive for perfection	○	○	○	○	○
Basically, there are two ways of doing things - the right way and the wrong way	○	○	○	○	○

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What are some of the best (most positive) life experiences you have had?

What are some of the things for which you feel a sense of personal accomplishment/satisfaction?

What do you consider to be your strengths or talents?

What is going right is your life right now?

Who, if anyone, can you count on now when you need them?

What else would you like me to know about you or think might be helpful for your work with me?