Better Being
Psychological Services, Inc.

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Client Information

Identifying Information

Today's Date: _____

Name: _____ Date of Birth:_____

Age: _____ Gender: _____ Race/Ethnicity: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip:_____ Phone: _____

*May voicemails be left? __Yes __ No *May text messages be sent? __Yes __No

Email: _____ *May emails be sent to this address? __Yes __No

Restrictions on phone/email communications: _____

Emergency Contact: Name:_____ Phone: _____

How did you learn about us? _____

Education and Training

Highest Level of Education Completed: _____

Trade/Technical School Completed: _____

Currently a student? __Yes __No If yes: __Full-time __Part-time; Major: _____

Years at this level of study: _____ Career goal: _____

Military Service

Military Service: __Yes __No If yes, branch:_____

Dates of Service:_____ Type of Discharge:_____

Deployments: _____

Employment

Current Employer: _____ Job Title: _____

Number of years at this job:_____ Number of jobs held in the last 10 years: _____

Have you ever been fired or asked to resign from a position? __Yes __No If yes, please explain:_____

If seeking a pre-employment psychological assessment:

*Please provide the job description written by potential employer.

What is the potential position?_____

Does this position require carrying/yielding a firearm? __Yes __No

Other potential special requirements: _____

Legal History

Have you ever been arrested? __Yes __No If yes, please explain: _____

Have you ever been incarcerated? __Yes __No If yes, please explain: _____

Have you ever been on probation? __Yes __No If yes, __Currently __In the past

Please explain: _____

Medical History

Current major medical problems (viruses, diseases, or major surgeries):_____
_____

Current medication for physical problem: _____

Past major medical problems (viruses, diseases, or major surgeries): _____
_____

Did you meet all developmental milestones as expected? __Yes __No If no, please explain:

_____

Family History

Marital Status (check all that apply): __Single/Never married; __Married (How long?____); __Separated (How long?____); __Divorced (How long?____); __Widowed (How long?___); __Committed relationship (How long?____)

How would you rate your social support? __Strong __Moderate __Weak __No social support

How many close friends/relatives do you have? _____

Who would you consider supportive in your life? _____

Family Member	Quality of Relationship	Living With You
Mother		__Yes __No
Father		__Yes __No
Step-parent(s) (List all below)		__Yes __No
Siblings (List all below)		__Yes __No
Romantic Partner		__Yes __No
Children (List all below)		__Yes __No

Have any of your relatives ever had a problem with alcohol or drugs use? __Yes __No

If yes, please explain: _____

Have any of your relatives ever had a mental health problem? __Yes __No

If yes, please explain: _____

Has anyone ever emotionally abused you? __Yes __No

Has anyone ever physically abused you? __Yes __No

Has anyone ever sexually abused you? __Yes __No

Substance Use History

Do you currently drink alcohol? __Yes __No If yes, __Rarely __Occasionally __Frequently

Do you smoke cigarettes? __Currently __Past If either, Average amount: _____

Have you use drugs? __Currently __Past If either, __Rarely __Occasionally __Frequently

Please identify substances you have tried below:

	Current Use (Days used in past 30 days)	Past Use (Average days used per month)	Last Used (Approximate date)
Alcohol	_____	_____	_____
Amphetamines	_____	_____	_____
Cocaine/Crack	_____	_____	_____
Hallucinogens	_____	_____	_____
Heroin	_____	_____	_____
Opiate/Opioids	_____	_____	_____
Inhalants	_____	_____	_____
Sedatives/Benzodiazepines	_____	_____	_____
Marijuana	_____	_____	_____
Other:_____	_____	_____	_____

Have you had any form of substance use treatment? __None __Outpatient __Inpatient

If yes, please list treatments: _____

Mental Health History

Have you ever been in outpatient psychotherapy? __Yes __No

If yes, approximate number of treatments: _____ Date of last treatment:_____

Have you ever been prescribed medication for mental health reasons? __Yes __No

Current medication for mental health reasons:_____

Past medications for mental health reasons:_____

Have you ever been hospitalized for mental health reasons? __Yes __No

If yes, how many hospitalizations: _____ Date of last hospitalization: _____

Circle all that apply to you:

Depressed	Restlessness	Loss of enjoyment	Heart palpitations/racing
Anxious	Panicky	Isolation	Poor concentration
Excessively happy	Distractible	Fatigue	Stomach Trouble
Anger/Irritability	Low motivation	Change in sleep	Sexual problems
Hopelessness	Worthlessness	Change in appetite	Aggressiveness
Trauma	Nightmares	Weight loss/gain	Difficulty making friends
Obsessions	Compulsions	Food Restriction	Binge/emotional eating
Delusions	Hallucinations	Suicidal Ideation	Thoughts of hurting others

Other symptoms not listed above:_____

_____

Presenting Problem

Please describe what brought you in today: _____

_____

_____

_____

When did this begin? _____

Please rate the severity of your presenting problem on a scale from 0 (no impact) to 10 (completely incapacitating): _____

What are your treatment goals? _____

_____

Signature: _____ Date: _____