Spectrum Psychological Associates, Inc.
Background Information

Personal Data of the Patient:

First Name: _____ Middle Initial: _____ Last Name: _____

Age: _____ Birth Date: ____/____/_____ SSN: _____

Briefly describe the reason for this appointment: _____

_____

_____

Please list any treatment goals or expectations that you have: _____

_____

Have you or anyone in your family used Spectrum Psychological Associates, Inc. services previously? _____
If yes, under what names: _____

Have you or anyone in your family ever seen a mental health provider? _____
If yes, who, when, and why?

_____

_____

What kind of work do you do? _____ Full time or part time? _____

What kind of work does your spouse/partner do? _____ Full time or part time? _____

Are you married? _____ If yes, how long? _____

Are you divorced? _____ If yes, how long? _____

Please list your highest level of education completed (for example: high school graduate): _____

Please list your spouse/partner's highest level of education completed: _____

Please list the names, ages and gender of your children.

Name	Age	Gender (circle one)
_____	_____	M / F
_____	_____	M / F
_____	_____	M / F
_____	_____	M / F

Do you have any medical or physical problems? _____ If yes, please describe:

_____

_____

Please list any medications you are taking (including dosage if known): _____

_____

_____

Do you have any significant medical problems in your family? _____ If yes, please describe:

_____

_____

PLEASE TURN OVER

Created 12/29/03; revised 01/19/04 (changed font size and separated adult/child questions); 02/18/04; 05/23/04 (changed font)

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Background Information

Do you smoke tobacco? _____ If yes, please list the amount: _____

Please list the amounts and types of beverages with caffeine that you consume on a daily basis:

_____

_____

How much alcohol do you drink in a typical week? _____

_____

Does anyone in your family have any problems with alcohol? _____ If yes, please describe:

_____

_____

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