Marek Dvorak, Ph.D.

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Adult Information and History

Today's Date: ___________________

Personal Information

Name ________________________________
Home Address
____
City/State/Zip
____

Home and Cell
Phone____

Work Phone ___________________________
Drivers License # _______________________

Date of Birth ___________________________
Social Security Number _________________
Marital Status _________________________
Occupation ____________________________
Employer /School_______________________
Work Address
____
City/State/Zip
____ Work
Phone ____

Name of Spouse/Partner
____

May we call you ...at home? yes no ...at work? yes no

Person completing form (if other than patient):______________________________
Relationship:___________________________
Name of Guardian (if applicable): __________________________________

Emergency Information

Contact person in case of emergency:___________________

Relationship:___________________

Phone #:______________________________

Physician Information

Primary Care Physician______________________________________

Phone Number_________________________________

Referred By ____________________________________

REASON FOR VISIT

Please describe your PRIMARY reasons for seeking therapy/counseling (include year/month the difficulties started):

Was there a significant event which made these issues or problems surface? Yes No If yes, describe:

What motivated you to get help now?

PLEASE INDICATE HOW YOUR PROBLEMS ARE AFFECTING THE FOLLOWING AREAS: (Place an X in the appropriate box)

	No Effect	Little Effect	Some Effect	Much Effect	Significant effect	Not Applicable
Marriage						
Family						
Job or School Performance						
Friendships						
Hobbies						
Financial Situation						
Physical Health						

Anxiety level						
Mood						
Eating habits						
Sleeping habits						
Sexual functioning						
Ability to concentrate						
Ability to control your temper						

Please answer whether or not you are CURRENTLY experiencing any of the following symptoms:

Suicidal Thoughts/Impulses .... Y N

Homicidal Thoughts/Impulses .... Y N

Appetite Problems .... Y N

Sleep Problems .... Y N

Physical Complaints .... Y N

Anger/Irritability .... Y N

Isolation/Social Withdrawal .... Y N

Anxiety/Panic .... Y N

Phobia .... Y N

Bingeing/Purging .... Y N

Poor Impulse Control .... Y N

Violence Toward Others .... Y N

Destruction of Property .... Y N

Strange or Unusual Behavior .... Y N

Confused or Irrational Thinking .... Y N

Bothersome Repetitive Thoughts or Behaviors Self-mutilation
.... Y N

Psychiatric History

Have you received any Psychological/Psychiatric treatment before? What was your age at the first visit? _____

No___ Yes___

If you checked Yes to the above question, please answer the following for the most RECENT TREATMENTS:

What type of care did you receive? Inpatient (hospital) Outpatient Both

Where were you in treatment?

____

How long were you in treatment?

____

Who was your therapist and psychiatrist?

____

Did your psychiatrist prescribe medicine at this time? Yes No Not applicable If yes, what was prescribed (include dosages if known)?

Substance Use History

How much alcohol do you drink per week on average? _____ drinks per week How much alcohol did you drink per week on average for the last 5 years? ______ drinks per week Have you had problems with your drinking (legal, health, work, relationship?)

No___ Yes___ If Yes, please explain:

____
____

Have you had any inpatient/hospital treatment for mental health or substance abuse? No___ Yes___

[If Yes, please list facility(ies) date(s) and length(s) of stay(s)]:

____
____

Did you or do you use any illicit drugs? Please list:

PAST _________________________

Yes

No

PRESENT __________________________
Please describe the alcohol and/or drug use for your PAST and PRESENT USE:

Substances
When? (first use, last use)

__________________________________ __________________________________
____

Do you have a history of blackouts, seizures, or withdrawal symptoms?

___________________________ ___________________________

Amount

Frequency

________________ ________________ ________________

Habits:
Coffee (cups/day) Cigarettes (packs/day) Alcohol

Amount Currently Using ______________________ ______________________

____

________ ________ ________

Current Medical Condition(s):

____

____

Please list any prescription medications you currently use:
NAME DOSAGE FREQUENCY

____ _____

_________________ ____

____

____

____

Please list any over-the-counter medications you CURRENTLY use:

NAME and DATE BEGAN DOSAGE FREQUENCY

____

____

____

____

____ __

____

Please list any past or present MEDICAL conditions that you have been treated for:

____

____

Have you ever had a brain injury or a neuropsychological exam? Yes No

Please describe:

When did you last have a physical examination?

____

Whom did you see?

____

Name Phone Number

Do you have any allergies? No___ Yes___ If yes, please list: ____
____

Family History

How many siblings did you have? Full ________ Half ________ Step ________

How many times was your mother married? _______________

How many times was your father married? ________________

Describe any significant conditions of your parents and/or other family members, and please list relationship to family member:

Emotional:

Medical:

Chemical dependency:

Developmental History

Did you experience any type of developmental delays as a child? Please describe:

Did you experience any type of learning difficulty or academic difficulty as a child? Please describe:

Goals

Please list your primary goals for treatment in order (begin with the most important):