Marek Dvorak, PhD

Licensed Psychologist (PSY 0004303)

6857 Paiute Avenue

Niwot, CO 80503

Adult Information and History

Today's Date _____

Personal Information

Full Name _____

Home Address _____

_____

City/State/Zip

Work Address _____

_____

City/State/Zip

Phone Numbers		May we call you at this number?		Prefered contact number
Home	_____	Yes ◯	No ◯	☐
Cell	_____	Yes ◯	No ◯	☐
Work	_____	Yes ◯	No ◯	☐

Email _____

Date of Birth _____

Occupation _____ Employer/School _____

Marital Status _____

Name of Spouse/Partner _____ Phone _____

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 _____

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

	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	☐	☐	☐	☐	☐	☐

	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect	Not Applicable
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:

	Yes	No
Suicidal Thoughts/Impulses	☐	☐
Homicidal Thoughts/Impulses	☐	☐
Appetite Problems	☐	☐
Sleep Problems	☐	☐
Physical Complaints	☐	☐
Anger/Irritability	☐	☐
Isolation/Social Withdrawal	☐	☐
Anxiety/Panic	☐	☐
Phobia	☐	☐
Bingeing/Purging	☐	☐
Poor Impulse Control	☐	☐
Violence Toward Others	☐	☐
Destruction of Property	☐	☐
Strange or Unusual Behavior	☐	☐
Confused or Irrational Thinking	☐	☐
Bothersome Repetitive Thoughts or Behaviors	☐	☐
Self-mutilation	☐	☐

Psychiatric History

Have you received any Psychological/Psychiatric treatment before? Yes ◯ No ◯

If yes

What was your age at the first visit? _____

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?) Yes ◯ No ◯

If Yes, please explain: _____

_____

_____

Have you had any inpatient/hospital treatment for mental health or substance abuse? Yes ◯ No ◯

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

_____

_____

Did you or do you use any illicit drugs?

Past? Yes◯ No◯

Please list _____

_____

Currently? Yes◯ No◯

Please list _____

_____

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? Yes◯ No◯

Amount _____ Frequency _____

Habits

Coffee (cups/day) _____

Cigarettes (packs/day) _____

Alcohol _____

Medical History

Current Medical Condition(s) _____

_____

_____

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

_____

_____

_____

Please list any prescription medications you currently use

Name	Date started	Dosage	Frequency

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

Name	Date started	Dosage	Frequency

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 _____

Do you have any allergies? Yes◯ No◯ 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 &/or other family members. List relationship to family member

Emotional _____

Medical _____

Chemical dependency _____

Developmental History

Did you experience any type of developmental delays as a child? Yes◯ No◯

Please describe: _____

Did you experience any type of learning difficulty or academic difficulty as a child? Yes◯ No◯

Please describe: _____

Goals

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

_____

_____

_____

_____

_____

_____