Annice Ormiston, Psy.D.
Clinical Psychologist PSY 25092
2000 Hearst Avenue, Suite 207, Berkeley, CA 94709
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ADULT HEALTH HISTORY AND PATIENT INFORMATION

Biographical Information

Name: _____

Address: _____

Date of Birth: _____ Age: _____

Ethnicity/Race: _____

Gender Identity: (female/male/transgender/other): _____

Sexual Orientation: _____

Relationship Status: (circle current) single/partnered/married/domestic partnership or civil union/ involved with multiple partners/separated/divorced/other, specify: _____

Current Living Situation: (circle current) live alone/with partner or spouse/with roommate(s)/with parents or other family members/other, specify: _____

Current Employment Status: (circle current) full-time/part-time/student/not employed outside home

If employed, where do you work? _____

If in school, where do you attend school? _____

Referred by: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Emergency Contact's Relationship to you: _____

Home Phone: _____ Is it OK to leave a message? ☐ No ☐ Yes

Cell Phone: _____ Is it OK to leave a message? ☐ No ☐ Yes

Work Phone: _____ Is it OK to leave a message? ☐ No ☐ Yes

Email: _____ Is it OK to email you? ☐ No ☐ Yes

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Health/Medical History

How would you describe your physical health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you experienced any significant medical issues (current/past)? ☐ No ☐ Yes

If yes, please describe: _____

Any past hospitalizations, surgeries, or serious injuries? ☐ No ☐ Yes

If yes, please describe: _____

Have you had any head injuries or injuries which resulted in a loss of consciousness? ☐ No ☐ Yes

If yes, please describe: _____

Any family members with psychiatric or substance abuse problems (current/past)? ☐ No ☐ Yes

If yes, please describe: _____

Have you ever been hospitalized for psychiatric reasons? ☐ No ☐ Yes

If yes, please describe: _____

Have you ever tried to harm or kill yourself? ☐ No ☐ Yes

If yes, please describe: _____

Have you ever experienced suicidal thoughts? ☐ No ☐ Yes

If yes, please describe: _____

Have you ever been in a physical fight that resulted in injury (for you or someone else)? ☐ No ☐ Yes

If yes, please describe: _____

How much alcohol and tobacco do you currently consume? _____ drinks/week _____ cigarettes/day

Do you feel you have ever had a problem with drugs (prescription, illicit) or alcohol? ☐ No ☐ Yes

Current drug use (type, frequency):_____

Past drug use: _____

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Previous Mental Health Treatment

Have you ever seen anyone for psychotherapy? ☐ No ☐ Yes

If yes, when and for how long? _____

_____

Are you currently under the care of a psychiatrist/therapist/nutritionist? ☐ No ☐ Yes

If yes (Name/Location): _____

_____

Do you have a primary care physician (or clinic)? ☐ No ☐ Yes

If yes (Name/Location): _____

Medication(s) are you currently taking, including psychiatric and other medications, including dosage:

_____

_____

What psychiatric medication(s) have you taken in the past?

_____

Please describe the concerns that have brought you to seek therapy at this time.

_____

_____

_____

_____

_____