SAN DIEGO
BEHAVIORAL MEDICINE

CLIENT INFORMATION

The information you provide below will be used to plan your treatment and is held strictly confidential. You may leave any item blank if you do not feel comfortable answering it. Thank you in advance for your efforts.

Name: _____ Date: _____/_____/_____
Last, First

Highest Level of Education Completed: _____

Cultural Background

Race/Ethnicity: _____ Does your family speak any other languages? ☐ No ☐ Yes: _____

Religious Involvement: _____

Medical History

1. Do you have any skin or other allergies? ☐ No ☐ Yes If Yes, please describe: _____

_____

2. Do you have any existing medical conditions? ☐ No ☐ Yes

If Yes, please list the condition(s) and how long you have been dealing with each: _____

_____

3. Have you ever stayed overnight in a hospital for medical, mental health, or substance abuse reasons? ☐ No ☐ Yes

If Yes, please list the year(s), reason(s), and duration of each stay: _____

_____

4. Please describe any other major medical illnesses or accidents in the past and when they occurred: _____

_____

5. Please list all medications you are currently taking:

Medication	Dosage	Frequency	Reason

6. If any of your family members have had any major medical medical (e.g., cancer, diabetes, hepatitis, high blood pressure) problems, please describe the condition(s) and how that person is related to you.

_____

_____

Health Characteristics

1. Are you having any difficulties with sleep? ☐ No ☐ Yes a. If Yes, How long has this been a problem? _____
   ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Sleeping too much ☐ Not feeling rested
2. During the past two weeks, how many hours do you usually sleep per night? _____
3. Are you having any concentration or memory difficulties? ☐ No ☐ Yes
   a. If Yes, How long has this been a problem? _____
4. Difficulties with your appetite or eating habits? ☐ No ☐ Yes If Yes, how long has this been a problem? _____
   ☐ Eating more ☐ Eating less ☐ Restricting food intake ☐ Forcing self to eat
5. During the last 12 months, how often do you exercise for ≥ 30 minutes?
   ☐ Daily/Nearly everyday ☐ 3-4 days/week ☐ 1-2 days/week ☐ < 1 day/week ☐ < 1 day/month
6. Substance Use

	Date of Last Use	Quantity & Frequency of current use
Caffeine:		
Alcohol:		
Cigarettes:		
Marijuana:		
Sleeping pills/Diet pills:		
Cocaine/Methamphetamine/Heroin/PCP/Hallucinogens:		

Legal Background

1. Are you currently involved in any lawsuits? ☐ No ☐ Yes ☐ Uncertain

   If Yes or Uncertain, explain: _____

Relationships

1. Who do you live with? _____
2. List children, if any, and their ages:

   _____

   _____
3. How often do you see or talk to friends? ☐ Daily ☐ Weekly ☐ 2-3 times/month ☐ < once per month ☐ Never
4. Who do you confide in? _____

Personal History

1. Birth order: _____ of _____ children born to biological parents
2. Where were you born and raised? _____
3. Please list all siblings (including step- if you lived with them) and their ages:

   _____

   _____
4. Describe any noteworthy family dynamics during childhood and/or currently:

   _____

_____

_____

5. Please rate the quality of your childhood: ☐ happy ☐ neutral ☐ unhappy

6. Were you ever abused as a child? ☐ No ☐ Yes

   If Yes, indicate types of abuse: ☐ emotional ☐ physical ☐ sexual

7. Have you ever been a victim of rape, assault, or violent crime as an adult? ☐ No ☐ Yes

8. Have you ever been witness to domestic or street violence? ☐ No ☐ Yes

9. Did you experience the death of a parent, close friend, sibling, or close relative as a child? ☐ No ☐ Yes

10. Are you a survivor of any violent or terrorizing political circumstances? ☐ No ☐ Yes

11. Did you experience any unusual events (early/late development, traumatic life events, etc.) that occurred during:

Infancy	☐ No	☐ Yes	_____
Childhood	☐ No	☐ Yes	_____
Pre teen years	☐ No	☐ Yes	_____
Teenage years	☐ No	☐ Yes	_____
Early Adult years	☐ No	☐ Yes	_____
Adulthood	☐ No	☐ Yes	_____

Additional Comments or Concerns

I will be asking you more questions during our initial session, but to be sure I do not overlook anything, please describe anything else about yourself or your concerns you think I should know about that may guide our work together.

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CLINICAL INFORMATION

Name: _____ Date: _____/_____/_____
Last, First

Chief Concern
Please describe the major concern(s) you would like psychological services to help with:

_____

_____

_____

How long have you been dealing with the problem(s)? _____

What made you decide to seek help now? _____

_____

Who felt you should seek treatment? (check all that apply): ☐ Myself ☐ Friend ☐ Family Member ☐ Employer

☐ Physician (name): _____ ☐ Other: _____

What do you hope to get from psychological services? _____

_____

Quality of Life
Please rate your current overall health by marking an X on the line below:

|----------|
Terrible Excellent

Please rate your ability to perform daily activities (dressing, house chores, errands, etc.) during the past week by marking an X on the line below:

|----------|
Terrible Excellent

Who or what makes it harder for you to cope with your difficulties(s)? _____

_____

What do you do for relaxation? _____

Who or what helps you cope with your difficulties(s)? _____

_____

Previous Psychological Treatment

Dates	Reason	Outcome (Note if positive, negative, neutral)

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BEHAVIORAL MEDICINE

CONTACT INFORMATION

Name: _____/_____
Last, First Middle Preferred Name

Social Security #: _____ - ____ - _____ Birthdate: ____ / ____ / _____ Age: _____ Gender: F / M

Occupation**(s)**: _____
Employment Status: F/T P/T Disabled Unemployed Retired

Marital Status: ☐ Never Married ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
(check all that apply)

Address: _____ _____
Number and Street City

_____ _____ May we send mail there? ☐ Yes ☐ No
State Zip Code

E-mail: _____ May we email you? ☐ Yes ☐ No
Please be aware email may not be confidential

Primary Phone: (_____) _____ - _____ May we leave a message? ☐ Yes ☐ No
☐home ☐work ☐mobile

Alternate Phone: (_____) _____ - _____ May we leave a message? ☐ Yes ☐ No
☐home ☐work ☐mobile

Special instructions/restrictions when calling or leaving a message: _____

_____

Referral Information

How did you find out about our services?

Name: _____

Address: _____
Number and Street / website City State Zip

May we have your permission to thank this person for the referral? ☐ Yes ☐ No

Emergency Care Information

Primary Physician: _____ Phone: (_____) _____ - _____

Address: _____
Number and Street City State Zip

Person to contact in case of emergency: _____ Relationship: _____

Phone: (_____) _____ - _____ Address: _____
Number and Street City State Zip

Fax: (_____) _____ - _____

SAN DIEGO
BEHAVIORAL MEDICINE

Corinna Young Casey, Ph.D.
Clinical Psychologist
License No. PSY20004

INSURANCE INFORMATION

Patient Name: _____
(First) (Last)

Patient's Date of Birth: _____/_____/_____ Gender of patient: Male Female

Patient's Address (stress/city/zip): _____

Patient's Phone: (_____) _____ Other (_____): _____

Patient Status: Single Married Other Employed Full-time student Disability Other
(check all that apply)

Patient's relationship to the policy holder: Self Spouse Child Other: _____

Policy Holder Name: _____
(First) (Last)

Policy Holder's Address: _____

Policy Holder's Phone: (_____) _____ Other (_____) _____

Policy Holder's Date of Birth: _____/_____/_____ Gender of Policy Holder: Male Female

Policy Holder's Employer: _____

Name of Insurance Plan or Program: _____

Policy Holder's ID #: _____ Policy Holder's SS#: _____

Group #: _____

Name or Type of Plan: PPO Indemnity HMO EAP Other: _____

Phone number for verification of benefits/eligibility (on back of card): (_____) _____

Address to send billing (on back of card): _____

Deductible: $_____ Amount already met: $_____ Co-pay: $_____

How many sessions are allowed in your plan? _____How many sessions were approved? _____

Name of Primary Care Physician: _____ Phone #: (_____) _____

Name of Referring Physician (if different from above): _____ Phone #: (_____) _____

Authorization Number: _____

I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits either to San Diego Behavioral Medicine.

Patient or authorized person's signaturea; _____

I authorize payment of medical benefits to San Diego Behavioral Medicine for services described.

Insured or authorized person's signature: _____

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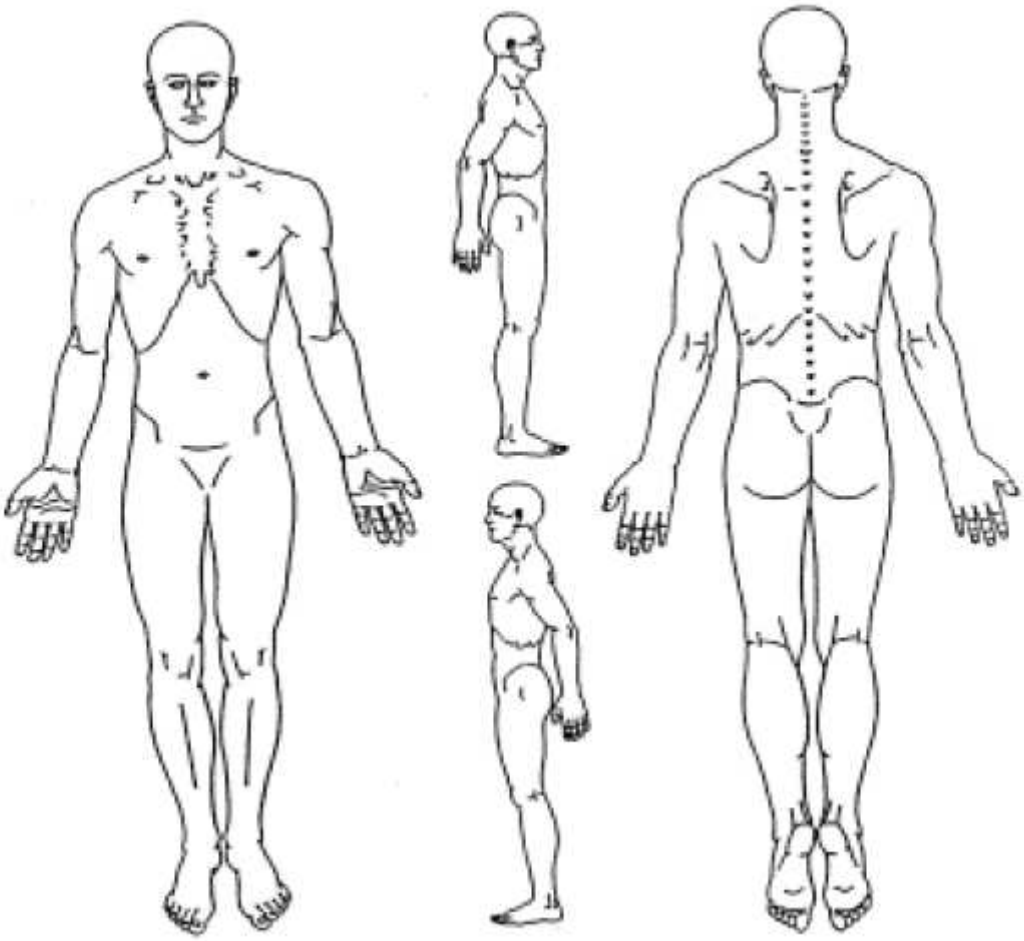
PAIN DRAWING

Please shade the areas of your body where you are experiencing pain.



Mark below your current level of pain

| _____ |
No pain Unbearable

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