Penson Psychotherapy Solutions, Inc.

Abby Penson, Ph.D.

Licensed Clinical Psychologist – PSY21602
11825 Major Street – Suite #207 • Culver City • CA • 90230
323-580-3383

CONFIDENTIAL PATIENT INFORMATION

General Information

Name _____

Date of Birth _____

Email _____

Home Phone _____

Work Phone _____

Cell Phone _____

Address _____

City _____ Zip _____

Parent/Guardian if Minor _____

Emergency Contact _____

Relationship _____

Phone _____

Names and ages of people living with you

_____

_____

Educational Level _____

Occupation _____

Cultural Heritage _____

Spiritual Orientation _____

Sexual Identity/Preference _____

Special Interests/Hobbies _____

_____

_____

Personal Strengths/Talents _____

_____

_____

Areas of Concern / Goals

What issues / concerns caused you to seek therapy?

_____

_____

_____

_____

What specific goals do you have for therapy?

_____

_____

_____

_____

_____

Please describe any concerns / fears about therapy

_____

_____

_____

_____

Have you ever had a bad experience in therapy? _____

If yes, describe _____

_____

_____

Insurance Information

Name of Insured _____

Date of Birth _____

Insurance Provider _____

Provider Phone # _____

ID Number _____

Group Number _____

Patient Name: _____

Therapeutic History

Have you had therapy before? _____ When? _____

For how long? _____ What was the focus of therapy?

_____

_____

Were you ever subjected to verbal, physical, emotional, or sexual abuse? _____

_____

Have you ever been the victim of a violent crime? _____

If yes, please describe _____

_____

Have you ever attempted suicide? _____ When? _____

Describe circumstances that led to the attempt(s) _____

_____

_____

Are you currently having any suicidal or murderous thoughts? _____ If yes, please describe the thoughts

_____

_____

How many times per day/week do you have the thoughts?_____

Medical History

Have you ever been diagnosed with a serious physical illness? _____ If yes, please describe _____

_____

_____

Do you have any medical conditions that may affect your therapy? Please describe _____

_____

_____

Please describe your overall health today _____

_____

Are you experiencing any physical symptoms you attribute to an emotional or stress related condition?

_____

_____

Have you ever been hospitalized for psychological problems? _____ When? _____

For how long? _____

Why were you hospitalized? _____

_____

_____

What prescription medications are you taking? _____

_____

_____

Prescribed by whom? _____

Have you ever taken medication for a mental or emotional condition? _____ When? _____

Physician / Phone _____

Psychiatrist / Phone _____

Family of Origin History

Mother's name / Age _____

Living / Deceased? Age at time of her death? _____

Cause of death? _____

Briefly describe your relationship with your mother

_____

_____

_____

Father's name / Age _____

Living / Deceased? Age at time of his death? _____

Cause of death? _____

Briefly describe your relationship with your father

_____

_____

_____

Names and ages of siblings _____

_____

Briefly describe your childhood _____

_____

_____

Please feel free to include any other information that you believe is relevant to your therapy _____

_____

_____

_____

_____

Patient Name _____

CONFIDENTIAL PATIENT INFORMATION

	None	Mild	Moderate	Severe	How Long?
Sadness or Depression	0	1	2	3	_____
Suicidal Thoughts	0	1	2	3	_____
Persistent Thoughts About Death	0	1	2	3	_____
Sleep Problems	0	1	2	3	_____
Appetite Change	0	1	2	3	_____
Weight Change	0	1	2	3	_____
Difficulty Concentrating	0	1	2	3	_____
Compulsive Behaviors	0	1	2	3	_____
Obsessive Thoughts	0	1	2	3	_____
Intrusive Thoughts	0	1	2	3	_____
Flashbacks	0	1	2	3	_____
Nightmares	0	1	2	3	_____
Tension / Anxiety	0	1	2	3	_____
Panic Attacks	0	1	2	3	_____
Nervous in Crowds	0	1	2	3	_____
Difficulty Being Alone	0	1	2	3	_____
Memory Problems	0	1	2	3	_____
Hostile / Angry Feelings	0	1	2	3	_____
Violent Acts	0	1	2	3	_____
Social Isolation	0	1	2	3	_____
Strange Thoughts	0	1	2	3	_____
Sexual Problems	0	1	2	3	_____
Other _____	0	1	2	3	_____

Alcohol Use: never 1-4 times/month 2-3 times/week daily How long?_____

Consumption 1-2 drinks/sitting 3-4 drinks/sitting 5 or more

Intoxication never 1-4 times/month 2-3 times/week daily

Substance Use: none marijuana sedatives stimulants

opiates cocaine hallucinogens

caffeine nicotine other _____

Frequency: never _____times/daily _____times/weekly _____times/monthly How long?_____

Do you or anyone in your family have a history or alcohol or substance abuse? _____

Was there treatment? _____

Have you ever been in a 12-step Program? Please describe _____

_____

_____

Have you ever been arrested? _____ If yes, When/Why _____

_____

_____