South Florida Psychological Associates, LLC

4121 SE 4th Avenue, Suite B
Plantation, FL 33316
(954) 909-7793

NEW CLIENT INFORMATION

Client Name : ____ Today's Date: __________________

Date of Birth: ___/____/_______ Age: ______ Gender: ______ Social Security # ____/____/_______

Marital Status (circle one): single married divorced/separated widowed other ________________

Address:

City: ____ State: __________ Zip Code: __________

Cell/Mobile Phone: _______________ Home Phone: ________________ Work Phone:________________

Email: ____ Fax: ______________________

THE BEST WAY TO REACH ME IS (circle one): Cell/Mobile Home Work Email

IS IT OK TO LEAVE MESSAGES REGARDING APPOINTMENT TIMES, ETC? (circle one): YES NO

IS IT OK TO SEND TEXT MESSAGES TO YOUR CELL/MOBILE? (circle one): YES NO

IS IT OK TO SEND MAIL TO THE ABOVE ADDRESS? (circle one): YES NO

IS IT OK TO SEND EMAIL'S TO THE ABOVE EMAIL? (circle one): YES NO

Please write any specific requests or limitations in communicating with you: _____________________________

____

Employed By: ________________________________ Occupation: ___________________ City: _____________

How were you referred to this office? (circle): Self-Referred Doctor Family Friend Ad Internet Other

Name of internet site/ad/treatment facility/other: ____

Whom may I thank for referring you? : ____

Emergency Contact Person: ____ Phone: _______________________

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ADULT SELF-REPORT FORM

CHIEF CONCERN:

Please describe the main difficulty that has brought you to seek treatment at this time: ________________________

____

____

YOUR MEDICAL CARE: (From whom or where do you get your medical care?)

Primary Care Doctor _______________________________ Phone: _________________ Fax: __________________

Date of Last Visit: _____________ Address: ____

Medical Problems: ____

Current medications prescribed by this provider: ____

May we contact your primary doctor so that we can coordinate your treatment? (circle one): YES NO

Psychiatrist: __________________________________ Phone: ___________________ Fax: ___________________

Date of Last Visit: _____________ Address: ____

Psychiatric Problems: ____

Current medications prescribed by this provider: ____

May we contact your psychiatrist so that we can coordinate your treatment? (circle one): YES NO

Have you received previous psychological care? (circle one): YES NO

If YES, please indicate which type of treatment (circle): INPATIENT OUTPATIENT BOTH

When: _________________From Whom: ___________________________ For What: _________________________

When: _________________From Whom: ___________________________ For What: _________________________

May we contact your previous providers(s) for continuity of care? (circle one): YES NO

EDUCATION:

Highest Degree Obtained: ______________________ From Where: _____________________________ Year: ______

PRESENT RELATIONSHIPS:

List All Individuals Currently Living With You:

NAME	AGE	RELATIONSHIP

How do you get along with your spouse/partner? ____

How do you get along with your children? ____

SUBSTANCE USE:

Do you currently consume alcohol? (circle one): YES NO

If yes, on average how many drinks per occasion do you consume? ____________

How many days per week do you consume alcohol? ___________

What kind of alcohol do you consume? (circle): BEER WINE LIQUOR Other _______________

Do you have a history of problematic use of alcohol? (circle one): YES NO

Have family members or friends expressed concern about your drinking? (circle one): YES NO

Do you currently use non-prescribed drugs or street drugs? (circle one): YES NO

If yes, what kind of non-prescribed drugs or street drugs do you take? ____

____

Do you have a history of problematic use of prescription drugs? (circle one): YES NO

Do you have a family history of alcohol or drug problems? (circle one): YES NO

If yes, please describe: ____

____

Do you currently smoke cigarettes? (circle one): YES NO

If yes, how many do you smoke per day? ___________ Per week? _____________

LIST OF SYMPTOMS: (Please check any of the following that have been bothering you lately):

____ ANGER
____ANXIETY
____ALCOHOL USE/ABUSE
____APPETITE
____AGORAPHOBIA
____AMBITION
____ASTHMA
____ALLERGIES
____BLOOD SUGAR PROBLEMS
____CHILDREN
____CONFIDENCE
____COMPULSIVITY
____CONFLICT
____CONCERN OVER HEALTH
____CHEST PAINS OR TIGHTNESS
____COLD HANDS OR FEET
____CONCENTRATION
____CAREER CHOICES
____DEPRESSION
____DIVORCE
____DIFFICULTY STAYING ASLEEP
____DIARRHEA
____DIZZINESS
____DRUG USE/ABUSE
____DWELLING ON THE PAST
____DECISION-MAKING
____DRIVING PHOBIA

____EXCESSIVE WORRY
____ENERGY (HIGH or LOW)
____EDUCATION
____EXCESSIVE EXERCISE
____FAINTING
____FAMILY VIOLENCE
____FINANCES
____FRIENDS
____FETISHES
____FEAR OF BEING ALONE
____FEAR OF PUBLIC PLACES
____FEAR OF CROWDS
____FEELING BORED
____FEELING HOPELESS
____FEELING HELPLESS
____FEELING WORTHLESS
____FRUSTRATION
____FEELING “BURNT OUT”
____FACE OR JAW PAIN
____FREQUENT URINATION
____FEELING EMOTIONAL
____GUILT
____HEART RACING
____HEADACHES
____HOMICIDAL
____HIGH BLOOD PRESSURE
____INADEQUACY

____IMPOTENCE
____INDIGESTION
____INABILITY TO RELAX
____INSOMNIA
____KNOTS IN STOMACH
____LONELINESS
____LYING
____LEGAL MATTERS
____LACK OF SEX DRIVE
____LOSS OF INTERESTS
____MARRIAGE
____MEMORY
____MIGRAINES
____MOODINESS
____NIGHTMARES
____NEGATIVE THOUGHTS
____NAIL BITING or HAIR PULLING
____NUMBNESS
____NERVOUSNESS
____OVER-EATING
____OBSESSIVE THOUGHTS
____OVERWEIGHT
____PANIC ATTACKS
____PERFECTIONISM
____PAINFUL THOUGHTS
____PAIN (back, neck, shoulders)
____PREOCCUPIED WITH DETAILS

____PREGNANCY
____POOR APPETITE
____RELATIONSHIPS
____RESTLESSNESS
____SEXUAL PROBLEMS
____SHYNESS
____SEPARATION
____SLEEP
____SUICIDALITY
____SELF-HARM
____SELF-CONTROL
____SELF-ESTEEM
____SPACING OUT
____SEXUAL ORIENTATION
____SHORT-TEMPER
____SEXUAL ABUSE
____SADNESS
____SERIOUS ILLNESS
____SOCIAL ISOLATION
____STRESS
____SEIZURES
____SUSPICIOUSNESS
____STARVATION
____TEARFULLNESS
____UNDERWEIGHT
____UNHAPPINESS
____VOMITING

For the next session, please use the following scale when answering. Write the number next to each area in the space provided:

- “1” = No Effect
- “2” = Little Effect
- “3” = Some Effect
- “4” = Much Effect
- “5” = Significant Effect
- N/A = Not Applicable

Please indicate how the issue(s) for which you are seeking treatment are effecting the following areas of your life, using the scale noted above:

MARRIAGE/RELATIONSHIP: ____________

FAMILY: ____________

MOOD: ____________

FRIENDSHIPS: ____________

FINANCES: _____________

PHYSICAL HEALTH: _____________

ANXIETY LEVEL/NERVES: __________

EATING HABITS: _____________

SLEEPING HABITS: _____________

SEXUAL FUNCTIONING: _____________

ALCOHOL/ DRUG USE: ______________

ABILITY TO CONCENTRATE: ___________

JOB/ SCHOOL PERFORMANCE: ___________

ABILITY TO CONTROL ANGER: ___________

OTHER:

What other information about yourself do you think would be important for us to know?

____

____

____

____ ____________________

PRINT Client Name Date

____ ____________________

SIGNATURE of Client Date