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**New Patient Information Form**

Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Name:

Birthdate: Age: Grade:

Gender: Primary Language:

Hand Preference:

**Contact Information**

Street Address:

City: State: Zip Code:

Home Phone: ( ) Other Phone: ( )

**Family Constellation –Adult Clients**

Significant Other’s Name:

Relationship to client:

 Age: Educational Level: Occupation:

 Employer: ­­­­­­­­­­­­ ­­­­­­

Does the client have children? (*circle one*) Yes No
 Name(s) Age Quality of Relationship

**Family Constellation –Child Clients**

Father’s Name:

 Age: Educational Level: Occupation:

 *Circle One*: Biological Parent Adoptive Parent Stepparent

Please describe the quality of their relationship:

Mother’s Name:

 Age: Educational Level: Occupation:

 *Circle One*: Biological Parent Adoptive Parent Stepparent

Please describe the quality of their relationship:

The parents are (*circle one*): Married Separated Divorced Never Married

Please explain.

If the client was adopted, at what age?

Is the client aware of the adoption? *Please explain.*

Please list all others living in the home:
 Name Age Relationship to Client

Please describe other significant figures in the client’s life.

Please describe cultural/ethnic identification and/or religious/spiritual affiliation and their role in family life.

**For what Problem(s) are you seeking help?**

General Behavior of Client/Child Patient(c*heck all that apply*):

* Friendly, Outgoing
* Shy
* Easygoing, Calm
* Irritable
* Hardworking
* Lazy
* Prefers Company
* Prefers to be Alone
* Optimistic
* Pessimistic
* Caring
* Uncaring
* Cooperative
* Stubborn
* Confident
* Expects Failure
* Sharing
* Selfish
* Respectful
* Defiant
* Takes Risks
* Cautious
* Generally Happy
* Generally Unhappy

Notes:

Problem Areas (*check all that apply*):

Thoughts

* Worries
* Fears
* Obsessive
* Compulsive
* Odd
* Disturbing

Notes:

Behavior

* Compulsive
* Repetitive
* Odd
* Messy
* Inattentive
* Short Attention Span
* Distractible
* Impulsive
* Hyperactive
* Accident Prone
* Runs Away From Home
* Tantrums, Angry Outbursts
* Bullies
* Argues
* Defiant, Oppositional
* Fights
* Lies
* Steals
* Legal Problems
* Destroys Property
* Sets Fires
* Cruel to Animals
* Reckless, Careless
* Disruptive

Notes:

Mood

* Mood Swings
* Sadness
* Depression
* Crying Spells
* Irritable
* Withdrawn
* Boredom
* Nervousness
* Anxiety

Notes:

Appetite

[ ]  Decrease [ ] Increase

[ ] Weight Changes

Additional Information:

Sleep

* Nightmares
* Night Terrors
* Insomnia
* Sleepwalking
* Will Not Sleep Alone

Additional Information:

School

* Missing School Due to Illness
* Skipping Classes/School
* Learning Problems
* Speech Problems
* Poor School Work

Additional Information:

**Developmental History**

Mother’s pregnancy was (*circle one*): Normal Complicated

Please explain:

Medication use during pregnancy? *Please describe.*

Client’s condition at birth (*circle one*): Normal Abnormal

Please explain:

Birth Weight:

As an infant, client was (*check all that apply*):

* Easy to Manage
* Alert/Responsive
* Irritable
* A Poor Eater
* Demanding
* A Poor Sleeper

Additional Information:

At what age did the client:

Sit up unassisted

Crawl

Walk without support

Toilet trained

Use words

Use sentences

Toilet training was (*circle one*): Easy Difficult

Notes:

**Significant Life Events**

Please indicate any important events in the client’s life (*check all that apply*):

* Change of residence
* Change of schools
* Change of custody
* Marital conflict
* Parents separated
* Parents divorced
* Parental visitation problems
* Post-divorce parental problems
* Parent(s) remarried
* Step-parent problems
* Sibling birth
* Step-sibling problems
* Family economic problems
* Family job problems
* Other family problems
* Rejection by family members
* Suffered/Witnessed significant accident/injury
* Other severe fright or trauma
* Death of family member
* Death of friend
* Death of pet

Please describe.

**School History**

Current School:

Street Address:

City: State: Zip Code: Phone: ( )

Current Grade Level:

Has the client repeated a grade? *Please explain.*

Has the client skipped a grade? *Please explain.*

Please describe the client’s academic grades.

Is or has the client even been involved in special education? *Please explain.*

Does the student have an IEP? yes[ ]  no[ ]

Is the student on a 504 plan? yes[ ]  no[ ]

Has there ever been any indication of a learning problem? *Please describe.*

Please describe the client’s study habits.

Please describe the client’s behavior in school.

Has the client ever been suspended or expelled from school? *Please explain.*

Is the client involved in extra-curricular activities? *Please describe.*

**Social/Recreational Activities**

What activities does the client do for fun? *Please describe.*

How many hours per week does the client engage in leisure activities?

Please describe the client’s friendships.

Is the client satisfied/happy with his or her social life? *Please explain.*

Notes:

**Adult Employment History**

Are you currently employed? (c*ircle one*) Yes No

Occupation:

Employer:

How many hours per week?

Please describe the nature of the employment.

Do you have problems with co-workers or supervisors? *Please explain.*

Are you satisfied with your job? *Please explain.*

Please describe past employment history:

 Employer Dates Description

Have you ever been fired? *Please explain.*

**Legal History**

Have you ever been involved in criminal or civil proceedings? (c*ircle one*) Yes No

If yes, please explain.

(*check all that apply*):

* Suspended/Revoked driver’s license
* Conviction for misdemeanor
* Conviction for felony
* DUI/DWI
* Shoplifting
* Assault/Battery
* Property Damage
* Other

Please explain.

Have you ever been charged or arrested for any offense involving drugs or alcohol? (*circle one*) Yes No

If yes, please explain.

Are you currently on probation? (*circle one*) Yes No

If yes, please explain the reason and terms of probation.

Is there a family history of legal problems? (*circle one*) Yes No

If yes, please explain.

Notes:

**Medical History**

Please describe the client’s current physical health.

Is the client currently taking medication? (*circle one*) Yes No

Please describe.

Has the client have allergies? (*circle one*) Yes No

If yes, please explain.

Has the client ever had a serious accident or injury? (*circle one*) Yes No

If yes, please explain.

Has the client ever been medically hospitalized? (*circle one*) Yes No

If yes, please explain.

Has the client ever undergone surgery? (*circle one*) Yes No

If yes, please explain.

Is the client sexually active? (*circle one*) Yes No

If yes, how many partners?

Please describe the client’s sexual orientation.

Has the sexual activity resulted in pregnancy? (*circle one*) Yes No

If yes, please explain.

Please describe the client’s knowledge of contraception.

Please describe the sources of sexual information available to the client.

Is there a family history of chronic illness or disease? (*circle one*) Yes No

If yes, please explain.

Notes:

**Alcohol and Substance Use Assessment**

Current use of alcohol? *Please describe frequency and amount of alcohol use.*

Has this ever been a problem for you? [ ]  Yes [ ]  No

Have you ever been in treatment for this? [ ]  Yes [ ]  No

Please explain.

Have you ever tried to stop drinking and/or using drugs? [ ] Yes [ ]  No

Is there a family history of alcohol and/or substance abuse? (*circle one*) Yes No

If yes, please explain.

 **Suicide Assessment**

Do you currently have suicidal thoughts/ideation? *Please describe.*

If you were to experience suicidal thoughts, what would keep you from acting on them?

Have you previously had suicidal thoughts/ideation? (*circle one*) Yes No

Have you ever attempted suicide? *Please describe.*

Do you know anyone who has committed suicide? (*circle one*) Yes No

*Please describe relationship to this person.*  ­­­­­

**Anger Concerns**

Do you or your child have problems with anger? (*circle one*) Yes No

If yes, please describe.

How do you or your child deal with frustration? *Please describe.*

Is there a family history of aggressive behavior, assaults, violence toward others?

(*circle one*) Yes No

If yes, please explain.

Notes:

**Abuse Assessment**

Have you ever experienced physical, sexual, and/or emotional abuse? *Please describe.*

Have you ever been a perpetrator of abuse? (*circle one*) Yes No

If yes, please explain.

Is there a family history of physical, sexual, or emotional abuse? (*circle one*) Yes No

If yes, please explain.

Have you ever witnessed acts of domestic violence? [ ] Yes [ ] No

Has your child ever witnessed acts of domestic violence? [ ] Yes [ ] No

If yes, please explain.

**Previous Mental Health Treatment**

Previous psychotherapy? [ ] Yes [ ] No

If yes, please indicate the setting, frequency, and length of treatment (optional - with whom): ­­

What was the treatment experience like?

Has the client ever taken psychotropic medication? [ ] Yes [ ] No

Please describe.

Is the client currently taking psychotropic medication? [ ] Yes [ ] No

Please describe.

Is there a family history of mental health problems? [ ] Yes [ ] No

If yes, please explain.

Have you or your child ever been psychiatrically hospitalized? (*circle one*) Yes No

If yes, please indicate the facility:

Dates of treatment:

Please describe the reason for hospitalization:

What was the treatment experience like?

Has the client ever been involved in residential treatment? (*circle one*) Yes No

If yes, please indicate the facility:

Dates of treatment:

Please describe the reason for treatment:

What was the treatment experience like for the client?