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Lisa Lombard, PhD 332 N. Scoville Ave.

Licensed Clinical Psychologist Oak Park, IL 60302

lisalombardphd.com

**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?