Teresa Welch
Licensed Psychologist, LLC

CLINICAL INFORMATION FORM

Note: If you were a patient here before, please fill in only the information that has changed.

A. Identification **Today's Date:**_____

Name:_____ Date of Birth:_____

Address:_____

_____

_____

Phone (Home):_____Phone (Work):_____

Phone (Cell):_____ E-mail:_____

In Case of emergency contact:_____ Phone:_____

B. Chief Concern

Please describe the main difficulty that has brought you to see me:_____

_____

_____

_____

_____

_____

_____

C. Treatment

1. Have you ever received psychological or psychiatric or counseling services before?
____No ___Yes If yes, please indicate:

When?	From whom?	For what?	With what results?

2. Have you ever taken medications for psychiatric or emotional problems? ____No ____ Yes
If yes, please indicate:

When?	From whom?	Which medications?	For what?	With what results?

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Name:_____

D. Relationships in your family of origin. Please describe the following:

1. Your parents' relationship with each other:_____
_____
_____
_____

2. Your relationship with each parent and with other adults present:_____
_____
_____
_____

3. Your parents' physical health problems, chemical use, and mental or emotional difficulties:_____
_____
_____
_____

4. Your relationship with your brothers and sisters, in the past and present:_____
_____
_____
_____

E. Abuse history: ____I was not abused in any way. ____I was abused. If you were abused, please indicate the following. For kind of abuse, use these letters:
P= Physical (such as beatings)
S=Sexual (such as touching/molesting, fondling or intercourse)
N=Neglect, such as failure to feed, shelter or protect you)
E=Emotional; (such as humiliation, etc.)

Your age	Kind of abuse	By whom?	Effects on you?	Whom did you tell?	Consequences of telling?

F. Present relationships:

1. How do you get along with your present spouse or partner?_____
_____
_____
_____

2. How do you get along with your children?_____
_____
_____
_____

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Name:_____

3. Your important friends, past and present:

Names	Good parts of relationships	Bad parts of relationship

G. Philosophy of Life

How important to you is your spiritual or religious life? _____
_____

H. Chemical use

1. Have you ever felt the need to cut down on your drinking or drug use? ____No ____Yes
2. Have you ever felt annoyed by criticism of your drinking or drug use? ____No ____Yes
3. Have you ever felt bad or guilty about your drinking or drug use? ____No ____Yes
4. Have you ever taken a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (as an eye-opener)? ____No ____Yes
5. How much beer, wine, or hard liquor do you consume each week, on the average?_____
   _____
6. How much tobacco do you smoke or chew each week?_____
7. Which drugs (not medications prescribed for you) have you used in the last 10 years?_____
   _____
   _____

Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects, and so forth:_____
_____
_____

I. Medical History

1. Your present height _____ weight _____ BMI (if known) _____
2. Have you had weight related issues in your life? ___No ___Yes If yes, please explain: _____
   _____
3. Are you currently receiving medical care? ___ No ___ Yes If yes, please explain: _____
   _____
   _____
4. List the medications you have been prescribed and are currently using: _____
   _____
5. Do you experience any side effects from these medications? ___ No ___ Yes If yes, please explain:
   _____

Name: _____

6. Any surgeries/accidents/hospitalizations? ___No ___Yes If yes, please explain the type and your age at that time:_____
_____
7. Have you previously been diagnosed with any physical developmental problems? ___ No ___ Yes If yes, at what age and what were the problems: _____
_____
8. Do you currently have a special need and/or medical, physical or learning disability? ___ No ___Yes If yes, please list: _____
9. Do you have any physical or health related problems I should know about? ___No ___Yes If yes, please explain: _____
_____

J. Legal History

1. Are you presently suing anyone or thinking of suing anyone? ____No ____Yes If yes, please explain:_____
_____
_____
_____
2. Is your reason for coming to see me related to an accident or injury? ____No ____Yes If yes, please explain: _____
_____
_____
_____
3. Are you required by a court, the police, or a probation/parole officer to have this appointment? ____No ____Yes If yes, please explain:_____
_____
_____
4. List all the contact with the police, courts, and jails/prisons you have had. Include all open charges and pending ones. Under "Jurisdiction," write in a letter (F=Federal; S=State, Co=County, Ci=City) Under "Sentence" write in the time and the type of sentence you served or have to serve (AR=Accelerated or Alternate Resolutions, CS=Community Service, F=Fine, I=Incarceration, Pr=Probation, Po=Parole, O=Other, R=Restitution).

Date	**Charge**	**Jurisdiction (F, S, Co, Ci)**	**Sentence (AR, CS, F, I, Pr, Po, O, R)**	**Probation/Parole Officer's Name**	**Your Attorney's Name**

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Name: _____

5. Your current attorney's name:_____ Phone:_____
6. Are there any other legal involvement I should know about?_____

_____

_____

K. Educational Information

1. What is your highest level of education and the year you completed it? _____
2. What was your primary course work or interest of study? _____
3. Do you have any disability as defined by The Americans with Disabilities Act? ___No ___Yes

If yes, please explain: _____

L. Employment Information

1. What is your current position? _____
2. List your work experience, your employer, positions, feelings about work: _____

_____

_____

_____

3. Have you served with the military? ___No ___Yes If so, what branch, what assignment(s), what location(s) and what years did you serve? _____

_____

M. Other

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper?

_____

_____

_____

_____

_____

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.