Richard B. Pazol, Psy.D.
LICENSED PSYCHOLOGIST

3601 South Green Road
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Confidential Information Sheet - Individual

Name: ______________________ Date of Birth __________ Today's Date: _________

Address: ____

Phone (C): ____________	OK to leave message?	☐ Yes	☐ No
	OK to text? (text not secure)	☐ Yes	☐ No
Phone (H): ____________	OK to leave message?	☐ Yes	☐ No
Phone (W): ____________	OK to leave message?	☐ Yes	☐ No
Email: ____________	OK to use? (email not secure)	☐ Yes	☐ No

Religion / Spirituality: ______________ Ethnicity: ______________

Occupation: ______________ Marital Status: ______________

Highest Level of Education / Grade Completed: ______________

Emergency Contact: ______________ Phone Number: ______________

Date of Last Medical Check-Up: __________ Referred by: ______________

Main reason(s) for seeking help:

____
____
____
____
____
____
____

How long have you had these problems or symptoms?

____
____

What have you tried?

____
____
____
____

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Were you raised by your biological parents? ☐ Yes ☐ No

Were you ever in foster care? ☐ Yes ☐ No

Please check off any items that apply to you:

Now	Past		Now	Past	
☐	☐	Chronic pain	☐	☐	Mood swings
☐	☐	Sleep Problems	☐	☐	Excess energy
☐	☐	Feeling depressed	☐	☐	Racing thoughts
☐	☐	Unable to enjoy life	☐	☐	Impulsive behavior
☐	☐	Weight loss/gain	☐	☐	Recurring unwanted thoughts
☐	☐	Eating problems	☐	☐	Recurring unwanted behaviors
☐	☐	Cutting/self-injury	☐	☐	Memory lapses
☐	☐	Thoughts of suicide	☐	☐	Sexual problems
☐	☐	Poor concentration	☐	☐	Anxiety
☐	☐	Relationship problems	☐	☐	Panic attacks
☐	☐	Hearing voices	☐	☐	Explosive anger
☐	☐	Seeing visions	☐	☐	Violent behavior
☐	☐	Suspicion/distrust	☐	☐	Traumatic loss/separations
☐	☐	Less sleep needed	☐	☐	Sexually abused
☐	☐	Physically abused	☐	☐	Neglected
☐	☐	Emotionally abused	☐	☐	Other (please specify)

____

____

MEDICAL INFORMATION

How would you rate your health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How would you rate your diet? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How would you rate your sleep? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

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How much caffeine do you drink?

____

How much do you exercise?

____

Do you smoke cigarettes? ☐ Yes ☐ No How many per day? ______________

Do you use marijuana? ☐ Yes ☐ No

Other street drugs? ☐ Yes ☐ No

Name(s)/Type(s): ______________________________

Prescription medications not prescribed to you? ☐ Yes ☐ No

Name(s)/Type(s): ______________________________

Do you drink alcohol? ☐ Yes ☐ No

How many days/week? __________ Type of alcohol ______________

How many drinks on days that you drink? ______________

Highest number of drinks you had in one day in the past month? ______________

Do you feel you have a problem with alcohol? ☐ Yes ☐ No Other drugs? ☐ Yes ☐ No

Please list any serious/chronic medical conditions:

____

Have you had any serious past accidents, head injuries (including concussions), or seizures?

☐ Yes ☐ No

If yes, type of accident/injury and approximate date/year: ______________

____

Please list dates and reasons for any psychiatric hospitalizations:

____

____

Have you ever attempted suicide? ☐ Yes ☐ No

Have you had any legal difficulties (inc. DUIs) or financial problems? ☐ Yes ☐ No

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Medications currently taken for depression, anxiety, sleep, etc.:

____

Who prescribes your current medication?

____

Medications taken in the past for depression, anxiety, sleep, etc.:

____

Family Information: Please list immediate family members, both alive and deceased.

Name	Relation	Age, if living	Where living	How do you get along?

Please list any relatives or significant others who have had emotional, psychological, neurological, drug or alcohol problems:

Name / Relation: ________________________Problem: ____

Name / Relation: ________________________Problem: ____

Name / Relation: ________________________Problem: ____

Name / Relation: ________________________Problem: ____

Name / Relation: ________________________Problem: ____

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OTHER

Why did you decide to seek help *at this time*? ____

____

____

____

____

Who else is helping you with this problem?

____

What previous counseling / therapy have you had?

____

____

____

How are you hoping therapy will help you?

____

____

____

How long are you expecting it will take?

____

Is there anything else I should know that might be important in helping you?

____

____

____