Christina Z. Atti, Psy.D.

Licensed Psychologist

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: _____ Date Hired: _____

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

Name of internet site/ad/facility/friend/other: _____

Emergency Contact Person: _____ Phone: _____

PLEASE DO NOT WRITE BELOW THIS LINE

Payment Due: $ _____ Diagnosis: _____

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

RACE/ETHNICITY:

(circle all that apply): American Indian or Alaska Native Asian Black or African American

Hispanic or Latino Native Hawaiian or Pacific Islander White Other: _____

RELIGION/SPIRITUALITY:

What religion/spiritual practices do you abide by, if any? _____

If religious/spiritual, in what ways do you practice or observe your faith? _____

_____

DEMOGRAPHICS:

What city and state were you born in? _____

If not from the area, how old were you when you moved here? _____

What brought you to this area? _____

EDUCATION:

Highest Degree Obtained: _____ Major: _____

From Where: _____ Year: _____

PRESENT RELATIONSHIPS:

Below, 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? _____

HOUSING:

Do you own the house you are living in? (circle one): YES NO If YES, what year did you buy it? _____

If NO, do you (circle all that apply): Rent Live with family Use Live with friends Other: _____

LEGAL:

Do you have any pending legal issues? (circle one): YES NO

If yes, please describe: _____

_____

Have you had any legal issues that have been settled in the last 10 years? (circle one): YES NO

If yes, please describe: _____

_____

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? _____

INTERESTS/HOBBIES:

What do you like to do in your spare time? _____

_____

_____

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