352 Seventh Avenue, Suite 306, New York, NY 10001
212-337-9990 (o) 212-337-9914 (f)
www.hartsteinpsychological.com

PATIENT INFORMATION (ADULT): DATE: _____

Name: _____

Date of Birth: _____ Age: _____

Address: _____

_____

Contact Information:	May we contact you at this number/address?	Any restrictions?
Home: _____	_____	_____
Cell: _____	_____	_____
Work: _____	_____	_____
Additional numbers: _____	_____	_____
Email address: _____	_____	_____

Primary Care Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Who referred you? _____ Phone: _____

Name: _____

PRESENTING PROBLEM:

REASON FOR REFERRAL: Please describe why you are seeking services at this time.

_____
_____
_____
_____
_____
_____

When did these problems begin?

_____
_____

Does anything seem to make the problem better or worse? Please describe:

_____
_____
_____
_____

What do you consider your strengths/the best things in your life at this time?

_____
_____

Current Symptoms:

Please check off which problems/symptoms apply to you within the past month:

- ☐ Sad/depressed mood
- ☐ Withdrawn
- ☐ Panic attacks
- ☐ Decreased appetite
- ☐ Excessive weight loss
- ☐ Increased sleep
- ☐ Early morning waking
- ☐ Poor attention/concentration
- ☐ Poor work performance
- ☐ Drug use
- ☐ Physical aggression/fighting
- ☐ Hearing voices/sounds
- ☐ Sexual problems
- ☐ Poor peer relationships
- ☐ Experienced trauma
- ☐ Suicidal thoughts
- ☐ Anxious/tense
- ☐ Fatigue
- ☐ Angry outbursts
- ☐ Increased appetite
- ☐ Purging
- ☐ Difficulty falling asleep
- ☐ Nightmares
- ☐ Hyperactivity
- ☐ Stealing
- ☐ Alcohol use
- ☐ Problems with the law
- ☐ Seeing things others don't see
- ☐ Inappropriate sexual behavior
- ☐ Poor family relationships
- ☐ Difficulty with life change/stressor
- ☐ Suicide attempt
- ☐ Nonsuicidal self-injurious behavior, without intent to die (e.g. self-cutting, burning)

Name: _____

TRAUMA HISTORY:

Has there been any history of trauma in your life? Trauma can include, but is not limited to: physical or sexual abuse, accidents, or serious injury. Y/N If yes, please explain:

_____
_____
_____

BACKGROUND INFORMATION:

Education level (circle highest level achieved):

Some high school High School graduate Some college
College graduate Graduate degree

Did you have any learning difficulties when you were a student (if so, please specify)? Y/N

_____
_____

Your occupation: _____

Marital Status: (please circle)

Single Dating Long-term relationship (not living together)
Married/domestic partners Divorced Separated Other

Please list all individuals who currently live with you:

Name: Relationship to you: Age:

_____
_____
_____
_____
_____
_____

If you have children not living with you, please write down the following information:

Child's Name: Child's age Where does child reside:

_____
_____
_____
_____

Have there been any deaths/separations in your family? Are there are any significant interpersonal conflicts that are impacting your functioning? If so, please explain (include dates, relationship to you):

_____
_____
_____

Name: _____

Is there a family history of psychiatric illness Y/N If yes, please explain:

_____
_____
_____
_____

How do you identify in terms of race/ethnicity?

_____

Please list any religious, cultural or social issues that may impact treatment:

_____
_____

Do you have any significant hobbies/interests? Y/N If yes, please describe:

_____
_____

Do you have a history of arrests/legal involvement? Y/N If yes, please explain:

_____
_____

MEDICAL HISTORY

Please list/describe any medical issues you have:

_____
_____
_____

Hospitalizations/Surgeries:

Dates Reason for Hospitalization/Surgery

_____
_____
_____

Current Medications/Reasons for use:

_____ _____
_____ _____

Name: _____

PREVIOUS PSYCHOSOCIAL TREATMENT

Have you ever had psychological/psychiatric treatment of any kind? Y/N

If yes, please list the treatments you have had (i.e.: Individual therapy, Family therapy, Group therapy, Psychopharmacology, Residential Treatment Center, Therapeutic Boarding School).

--Be sure to include: dates of treatment, previous provider's name and contact information, and reason for termination of treatment.

_____

_____

_____

_____

_____

_____

Was there anything you found particularly effective or ineffective in your past treatment?

_____

_____

_____

Psychiatric Hospitalizations (Please include dates, length of stay, and reason for hospitalization):

_____

_____

_____

_____

Psychiatric Medications (Please indicate what medication and, if discontinued, reasons for change or stoppage of medication):

_____

_____

_____

If you are currently on psychotropic medication, please write the name and phone number of the psychiatrist or doctor who prescribes it:

_____

_____

ADDITIONAL INFORMATION

Please use this space to describe any other issues, questions or concerns. Feel free to write on the back of this paper if you need more space.

_____

_____

_____

Name: _____