Betty-Shannon Prevatt, MA, LPA
Clinical Psychologist

PERSONAL HISTORY FORM

SECTION I: Client Information

Client ID #: _____ Date: _____ DX: _____
(For Office Use Only)

Name of Client: _____ Age: _____ DOB: _____

Social Security Number: _____ Referred by: _____

Address: _____

_____

Home Phone: _____ Work Phone: _____ Other: _____

May I leave a message at home? Yes____ No____ At work? Yes____ No____ On cell? Yes____ No____

Email Address: _____

Place of Employment: _____

Occupation: _____ Hours Worked: _____

Relationship Status: Single____ Married____ Partnered____ Divorced____ Widowed____
Other_____

Name of spouse/partner or closest friend or relative to you: _____

Relationship (if other than spouse/partner): _____

Phone Number: _____ Place of Employment: _____

Chief complaint or issues you are concerned with: _____

List any major health problems for which you currently receive treatment: _____

_____

List all medications you are currently taking: _____

_____

Current prescribing physician/psychiatrists: _____

Have you ever received psychiatric help or counseling of any kind before? _____

If so, when and with whom?_____

What issues were addressed? _____

Do you use alcohol? (mark one) Never___ Occasionally___ Often___ Daily___

Do you use drugs? (mark one) Never___ Occasionally___ Often___ Daily___

How is your physical health? Excellent___ Good___ Fair___ Poor___

SECTION II: Identification of Symptoms

Please rate all responses based on level of distress or concern.

1	2	3	4	5
None		Moderate		Extreme

1. Ambition _____
2. Career choices _____
3. Fears _____
4. Unrealistic self-expectations _____
5. Making decisions _____
6. Concentration/Memory _____
7. Coping skills _____
8. Sleep difficulties/Insomnia _____
9. Lack of intimate relationships _____
10. Conflicts in intimate relationships _____
11. Physical violence in intimate relationships _____
12. Loss of intimate relationships/Divorce _____
13. Parenting _____
14. Family Conflicts _____
15. Family member with alcohol or substance abuse _____
16. Lack of social contact/shyness _____
17. Commitment issues _____
18. Death or impending death of a friend, family member or partner _____
19. Religious /Spiritual concerns _____
20. Multicultural issues/concerns _____
21. Financial concerns _____
22. Legal concerns _____
23. Low self-esteem _____
24. Feelings of extreme loneliness _____
25. Emotional abuse _____
26. Accident, trauma, assault _____
27. Sexual harassment _____
28. Sexual abuse as a minor _____
29. Rape/Sexual assault _____
30. Sexual identity concerns _____
31. Adjustment to major life changes _____
32. Depression _____
33. Irritable/angry feelings _____
34. Anxiety/stress _____
35. Panic attacks _____
36. Obsessive thoughts/compulsive behavior _____
37. Thoughts of suicide _____
38. Past attempts of suicide (yes or no) _____
    # of attempts (if none, put zero) _____
39. Impulsive behavior _____
40. Bizarre or strange thoughts _____
41. Self mutilation _____
42. Severe premenstrual syndrome (PMS) _____
43. Pregnancy/abortion concerns _____
44. Infertility _____
45. Sexually Transmitted Disease _____
46. AIDS/HIV issues (self, friends, family) _____
47. Weight concerns/body image issues _____
48. Health Concerns _____
49. Serious illness, past or present _____

Which #'s above are of most concern?

Most important is # ____
Next important is # ____
Next important is # ____

SECTION III: Responsible Party (complete only if client is younger than 18 years old)

Father's Name: _____ Date of Birth: _____
Father's Employer: _____ Work Phone: _____

Mother's Name: _____ Date of Birth: _____
Mother's Employer: _____ Work Phone: _____

Parent's Home Phone Number (if different from client's): _____
Parent's address (if different from client's): _____
_____

SECTION IV: Insurance Information

If you believe your insurance may cover a portion of your visits here, please complete the following information (please read "Client Services Contract" carefully):

Insurance Company: _____

Address: _____

Insurance Plan Name: _____

Phone Number of Insurance Company: _____ ID Number: _____

Policy Number: _____ Group Number: _____

Name of Policy Holder (if different from client): _____

Policy Holder's Date of birth (if different from client): _____/_____/_____

Address of Policy Holder (if different from client): _____

_____

Policy Holder's Place of Employment: _____

Relationship of insured to client (if applicable): _____

Secondary Insurance Company (if applicable): _____

Address: _____

Insurance Plan Name: _____

Phone Number of Insurance Company: _____ ID Number: _____

Policy Number: _____ Group Number: _____

I give permission for Betty-Shannon Prevatt, MA to release any information obtained throughout the course of my treatment to my insurance company.

Signature: _____ Date: _____

I understand that Betty-Shannon Prevatt, MA, LPA does not file insurance and that I may file for reimbursement from my insurance. I understand that the fee for services is my responsibility and I agree to pay in full for my sessions at the time of service unless another payment agreement has been made in writing.

Signature: _____ Date: _____