Supportive Psychological Services, PLLC

Marilyn Cabay, PhD

4300 N. Miller Rd., Suite 110-5
Scottsdale, AZ 85251
(602) 717-2589
marilyn.cabay@gmail.com

New Client Personal History

Please provide the following information and answer the questions below to the best of your ability. Please note information you provide here is protected as confidential information.

Name: _____ Date: _____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: _____

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

Previous therapist/practitioner_____

Marital Status (more than one answer may apply)

□ Single □ Married □ Unmarried, living together

□ Recently Separated □ Divorced □ Divorce in process

□ Widowed ____Total number of marriages

Assessment of current relationship (if applicable): □ Good □ Fair □ Poor

Do you have any children? □ No □ Yes

Please list names, ages, and if they are living and/or living with you:

_____

_____

_____

Anyone else living with you? (roommate, brothers, sisters, grandparents, step-relatives, half-relatives. Please specify relationship, age, if they are living, and/or living with you.

_____

_____

Parental Information

_____ Parents married
_____ Parents have been separated
_____ Parents ever divorced
_____ Adopted
_____ Deceased

___ Mother remarried: Number of times: _____
___ Father remarried: Number of times: _____
_____ Your age at the time of their divorce
_____ Foster Care: Number of homes: _____

Special circumstances (e.g., raised by person other than parents, information about spouse and/or children not living with you, etc.):

_____

Development

Are there special, unusual, or traumatic circumstances that affected your development?

□ No □ Yes

If Yes, please describe: _____

Were you abused as a child? □ No □ Yes

If Yes, please describe _____

Other childhood issues: ___ Neglect ___ Inadequate nutrition ___ Other (please specify): _____

Comments:_____

Social Relationships

Check how you generally get along with other people: (check all that apply)

□ Affectionate □ Aggressive □ Avoidant □ Fight/argue often
□ Follower □ Friendly □ Leader □ Outgoing
□ Shy/withdrawn □ Submissive □ Other (specify): _____

Sexual orientation: _____ Comments: _____

Sexual dysfunctions? □ No □ Yes If Yes, describe: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

_____

_____

Cultural/Ethnic

With which cultural or ethnic group do you identify? _____

Are you experiencing any problems due to cultural or ethnic issues? □ No □ Yes

If Yes, describe: _____

Legal

Are you involved in any active cases (traffic, civil, criminal)? □ No □ Yes _____

If Yes, please describe and indicate the court and hearing/trial dates and charges: _____

_____

Presently on probation or parole? □ No □ Yes

If Yes, please describe: _____

Medical/Physical Health Problems:

_____ AIDS
_____ Alcoholism
_____ Abdominal pain
_____ Abortion
_____ Allergies
_____ Anemia
_____ Arthritis
_____ Asthma
_____ Bronchitis
_____ Incontinence
_____ Cancer
_____ Chest pain
_____ Chronic pain
_____ Diabetes
___ Dizziness
___ Drug abuse
___ Epilepsy
___ Ear infections
___ Eating problems
___ Fainting
___ Fatigue
___ Headaches
___ Hearing problems
___ High blood pressure
___ Kidney problems
___ Memory problems
___Miscarriages
___ Neurological disorders
___ Sleeping disorders
___ Stroke
___ Sexual problems
___ Thyroid problems
___ Vision problems
___Other (describe):
_____
_____
_____
_____
_____
_____

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

_____

What types of exercise to you participate in and how often?

_____

_____

Please list any difficulties you experience with your appetite or eating patterns:

_____

_____

Are you currently experiencing overwhelming sadness, grief or depression?
□ No □ Yes If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No □ Yes If yes, when did you begin experiencing this? _____

Are you currently experiencing any chronic pain? □ No □ Yes If yes, please describe on *attached form.*

Chemical Use History

Substance	First Use	Last Use	Frequency
Alcohol			
Barbiturates			
Cocaine/Crack			
Heroin/Opiates			
Marijuana			
PCP/LSD/Mescaline			
Inhalants			
Caffeine			
Nicotine			
Other drugs			

Do you take vitamin or herbal supplements? □ No □ Yes
If Yes, please describe: _____

_____

Do you have a prescription for medicinal marijuana? □ No □ Yes
If Yes, for what reason? _____

Counseling/Prior Treatment History

(Circle)	Yes	No	When	Where	Benefit
Counseling/Psychiatric care	___	___	_____	_____	_____
Suicidal thoughts/attempts	___	___	_____	_____	_____
Drug/alcohol treatment	___	___	_____	_____	_____
Hospitalizations	___	___	_____	_____	_____
Self-help Groups	___	___	_____	_____	_____

Family Health History

Indicate if there is a family history and the relationship to you (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

Other relevant family health history: _____

_____

Your Personal Mental Health History

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

_____ Aggression	___ Elevated mood	___ Phobias/fears
_____ Alcohol dependence	___ Fatigue	___ Recurring thoughts
_____ Anger	___ Gambling	___ Sexual addiction
_____ Antisocial behavior	___ Hallucinations	___ Sexual difficulties
_____ Anxiety	___ Heart palpitations	___ Sick often
_____ Avoiding people	___ High blood pressure	___ Sleeping problems
_____ Chest pain	___ Hopelessness	___ Speech problems
_____ Cyber addiction	___ Impulsivity	___ Suicidal thoughts
_____ Depression	___ Irritability	___ Thoughts disorganized
_____ Disorientation	___ Judgment errors	___ Trembling
_____ Distractibility	___ Loneliness	___ Withdrawing
_____ Dizziness	___ Memory impairment	___ Worrying
_____ Drug dependence	___ Mood shifts	___ Other (specify): _____
_____ Eating disorder	___ Panic attacks	_____

Additional Information

Are you currently employed? □ No □ Yes Looking for work? □ No □ Yes

A student? □ No □ Yes Retired? □ No □ Yes

What is your current and/or was your previous employment? _____

Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:_____

Would you like your spiritual/religious beliefs incorporated into the counseling?

□ No □ Yes

What do you consider to be some of your strengths?_____

_____

_____

What do you consider to be some of your weakness?_____

_____

What significant life changes or stressful events have you experienced recently:

What would you like to accomplish out of your time in therapy?

Any other information you would like me to know?