Cressida A. Forester, Psy. D.

Licensed Psychologist, Psy 18902

Name Date

Date of Birth

Home Address

Phone cell Email
OK to use voice-mail? Y/N OK for scheduling? Y/N

Emergency contact info

Relationship to you

Date of last physical examination

Current medical conditions (including allergies)

Current medications (include herbal/alternative etc, with dosage and start-date)

Prescribing doctor and phone number

Past health problems, surgeries/hospitalisations/major illness.

Use extra page if needed. Add any other categories or details as you want.

Have you ever experienced bullyi ng? Y N

What happened?

Have you or someone you know experienced prejudice based on your identity/beliefs?
Y N

What happened?

List with dates any traumas, accidents, or losses you or someone you are close to have had or witnessed e.g.: physical/sexual/emotional abuse, neglect, death, jail, divorce.

Use extra page if needed. Add any other categories or details as you want.

Have you ever been hospitalised or in residential treatment for any reason: Y N
Date/s:

Past history of therapy? Dates? Frequency?

Please indicate which of these substances you use or have used:

Substance	Now?	Past?	Amount used?	How often?
Cigarettes				
Alcohol				
Marijuana				
Cocaine or crack				
Heroin				
LSD				
Ecstasy				
Pills not prescribed for me (list)				
Other				

Use extra page if needed. Add any other categories or details as you want.

Do you have any of the following problems, or have you had them in the past?

	Now	In the past
Difficulty falling or staying asleep		
Sleeping too much		
Change in appetite, weight loss or gain		
Frequent crying		
Panic or anxiety attacks		
Sadness or depression		
Sadness or depression for more than two weeks		
Feel I'm an outsider		
Persistent anger		
Frequent arguments with others		
Thoughts of hurting myself		
Hurting myself		
Thoughts of killing myself		
Attempts to kill myself		
Thoughts of physically hurting others		
Physically hurting others		
Problems concentrating		
Problems remembering things		

Use extra page if needed. Add any other categories or details as you want.

	Now	In the past
Startling easily		
Nightmares		
Feeling hyper-vigilant		
Feeling numb (emotionally or physically)		
Obsessive thoughts		
Compulsions		
Thoughts racing		
Can't stop remembering upsetting things		
Difficulty controlling my temper		
Breaking things in anger		
Worrying a lot		
Little or no interest in sex		
Sexual problems		
Sexual preoccupations		
Feel tired almost every day		
Feelings of unreality or dissociation		
Worry about my body		
Throw up/use laxatives to loose weight		
Exercise excessively		
Over-eat		

Use extra page if needed. Add any other categories or details as you want.