Jill C. P. Ilagan, Psy.D.
Licensed Clinical Psychologist

Date_____ Referred by_____

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session or allow yourself twenty minutes prior to your appointment to complete the form in the office.

Personal Information

Name_____

Date of Birth_____ Social Security #_____

Address_____

City_____ State_____ Zip code_____

Home Phone: ( ) _____ May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) _____ May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No
***Please be aware that email might not be confidential.**

Gender: Male ( ) Female ( ) Age: _____

Occupation _____

Place of Employment: _____

Name of Insurance Company: _____

Member ID#: _____

Group ID#: _____

Phone numbers on back of card: _____

_____

Marital Status:
□ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Spouse's Name if married_____

Emergency Contact: Person/Relationship_____

Phone/Address for Emergency Contact: _____

Family Information

People Currently Living in your Household

Name	Relationship	Age	Birthplace	Occupation or Grade Level

Original Family Members (mother, father, siblings...)

Name	Relationship	Age	Where Living	Occupation or Grade Level

Do you have any children not living with you? If yes, please list their names, ages, and where living:_____

_____

Has any member of your family been hospitalized for mental health concerns?_____

If yes, please list who, when, and for what reason:

_____

_____

_____

_____

Do/did you have any family members who have/had problems with drinking alcohol or using drugs? _____

If yes, please list who, when and if it is still a problem:

_____

_____

_____

_____

Has any member of your family killed themselves or tried to kill themselves? _____

If yes, please list who, when, and what happened:

_____

_____

_____

_____

Health/Mental Health Information

Have you ever seen a counselor, psychologist, psychiatrist or other mental health professional for any mental health or drug/alcohol concerns?_____

If yes, please list who, when, and why:

_____

_____

_____

_____

Have you ever been hospitalized for mental health or drug/alcohol concerns?_____

If yes, please list when and for what reason:

_____

_____

_____

_____

Do you have thoughts of killing yourself? _____ If yes, how often does this happen?

_____Have you ever tried to kill yourself? _____

If yes, when was this? _____ Did you receive medical help? _____

Please check any of the following areas that you have experienced:

( ) Head Injury ( ) Loss of Consciousness ( ) Seizures ( ) Convulsions

If yes, please explain: _____

Current Medications
(Please include prescription, over the counter, herbs, vitamins, and other remedies)

Medication	Dosage and When Taken	Reason for Taking

Past Medications
(Particularly those taken for Mental Health Concerns)

Medication	Dosage and When Taken	Reason for Taking

Have you ever had surgery? _____ If yes, please list when, where, why and type of surgery _____

_____

_____

_____

Height _____ Weight _____ Has your weight gone up or down by more than a few pounds in the past 3 months? _____ If yes, how much? _____
Are you satisfied with your weight? _____

Please list any current health concerns: _____

_____

_____

_____

Please list past serious illnesses and health concerns: _____

_____

_____

_____

Exercise and Physical Recreational Activity

Type of Activity	How often

Would you describe yourself as physically active? _____
Are you more or less active than 3 mos ago? _____ 6 mos ago? _____

Use of Substances (on Average)

	Current Amount	Most Used in the Past
Alcohol	_____ glasses per day or _____ glasses per week	_____ glasses per day or _____ glasses per week
Tobacco	_____ cigarettes per day	_____ cigarettes per day
Caffeine (tea, coffee, soda)	_____ servings per day	_____ servings per day
Marijuana	_____ per day or _____ per week	_____ per day or _____ per week
Cocaine	_____ times per day or _____ times per week	_____ times per day or _____ times per week
Diet Pills Name: _____	_____ pills/doses per day or _____ pills/doses per week	_____ pills/doses per day or _____ pills/doses per week
Laxatives	_____ times per day or _____ times per week	_____ times per day or _____ times per week
Stimulants Name: _____	_____ pills/doses per day or _____ pills/doses per week	_____ pills/doses per day or _____ pills/doses per week
Painkillers Name: _____	_____ doses per day or _____ doses per week	_____ doses per day or _____ doses per week
Other Name: _____ Name: _____	Amount:	Amount:

Relationships

What if any relationships do you have that are not going well at this time?

_____

_____

_____

What if any relationships do you have that are supportive and fulfilling at this time?

_____

_____

_____

Please check any symptoms that describe how you feel, think, or behave currently or during the past few weeks:

( ) Chronic sadness
( ) Low frustration tolerance
( ) Crying episodes
( ) Irritability
( ) Hopelessness
( ) Sleep problems
( ) Difficulty concentrating
( ) Memory problems
( ) Loss of appetite
( ) Thoughts of suicide
( ) Reduced interest in activities
( ) Withdrawing from others
( ) Nausea/Vomiting
( ) Difficulty functioning at work
( ) Difficulty making decisions
( ) Overeating
( ) Difficulty functioning socially
( ) Low energy/fatigue
( ) Agitation
( ) Panic attacks
( ) Restlessness
( ) Fear of leaving home
( ) Excessive worry
( ) Avoidance of public places
( ) Fearfulness
( ) Avoidance of social situations
( ) Trembling/shaking
( ) Pounding heart/palpitations
( ) Fear of loss of control
( ) Shortness of breath
( ) Fear of dying
( ) Feeling detached from others/life
( ) Intrusive thoughts of bad memories
( ) Nightmares
( ) Flashbacks/re-living bad experiences
( ) Easily startled/upset
( ) Hear voices others do not hear
( ) Seeing things others do not see
( ) Fearful others are talking about me
( ) Fearful someone is plotting against me
( ) Difficulty completing tasks/distracted
( ) Taking on too many tasks
( ) Difficulty focusing
( ) Frequent forgetfulness
( ) Tendency to act impulsively
( ) Difficult to wait my turn
( ) Not well organized
( ) Problems with co-workers
( ) Legal Problems
( ) Problems in school growing up
( ) Difficulty at work
( ) Hard to stay with a job very long
( ) Racing thoughts
( ) Staying up for days without sleep
( ) Excessive spending
( ) Multiple sexual partners
( ) Excessive gambling
( ) Marital conflict
( ) Aggressive/abusive toward others
( ) Confused/worried about sexual behavior
( ) Tried to kill myself
( ) Thoughts of physically hurting others

What are your strengths? _____

Please describe why you are seeking help at this time: _____