Cognitive Behavioral Therapy Services, Inc.

2111 S. El Camino Real Suite 302 · Oceanside, CA · 92054 · Tel: 760.730.0521 · Fax: 760.730.0581

Please provide the following information to help us in planning services for you. All information is kept confidential and will not be released without your prior consent.

Patient Name: Home Tel: ( ) - Cell/Work: ( ) -

Date of Birth: - - Marital Status: Remarried?

Education (Yrs.): Highest Degree:

Home Address: City: State: Zip:

Names of Parents/Guardians (***if minor***):

Father's Name:

Home Tel: ( ) - Cell/Work: ( ) -

Patient's Occupation: Position: How long?

Employer:

Work Address: City: State: Zip:

Name of Primary Physician:

Physician's Address : City: State: Zip:

Physician's Tel: ( ) - Fax: ( ) -

Are you currently seeing a Psychiatrist?

Psychiatrist 's Address : City: State: Zip:

Tel: Fax:

Please list any people currently living in your home:

Name: Age: Relationship:

Name: Age: Relationship:

Name: Age: Relationship:

Name: Age: Relationship:

Person to notify in case of an emergency (required information):

Name: Relationship:

Address: City: State: Zip:

Home Tel: Cell/work:

Please complete this section if you believe insurance may cover all or a portion of your visits:

Insurance Co: Name of policy holder:

Group#: Policy#:

I_____________________________________ hereby authorize the clinicians and administrative staff from Cognitive Behavioral Therapy Services to release any information to the above named insurance company which might be needed to process this claim. This information may include the diagnosis, dates of service and any other needed information to assist in the processing your claim. Your information may also be shared with Theramanager to aid in your billing and your insurance claims.

____ _____________________________

Signature Date:

Cognitive Behavioral Therapy Services, Inc.

I. Current Problems

*What are the chief problems that caused you to seek treatment at this time:*______________________________

____

____

____

____

____

____

Rate the severity of your problems **described above by entering number from scale below** _______________

None	Slight	Mild	Moderate	Very	Extreme	Totally Incapacitating
0	1	2	3	4	5	6

Have you been experiencing any these problems listed?If yes, please indicate how long you have had the symptom. Example: Nervousness (3 weeks)

Nervousness ( )	Depression ( )	Fears ( )	Mood Changes ( )
Shyness ( )	Sexual Problems ( )	Suicidal ( ) Thoughts	Family Conflict ( )
Divorce ( )	Boredom ( )	Finances ( )	Racing Thoughts ( )
Drug Use ( )	Alcohol Use( )	Friends ( )	Confusion( )
Anger ( )	Self-control( )	Unhappiness ( )	Attention( )
Sleep ( )	Stress( )	Work ( )	Organization ( )
Relaxation( )	Headaches( )	Dating ( )	Social Anxiety ( )
Legal Matters ( )	Chronic Pain( )	Decision ( ) Making	Thinking Problems ( )
Loneliness ( )	Self-esteem( )	Concentration ( )	Obsessions ( )
Education ( )	Career Choices ( )	Performance Anxiety ( )	Compulsiveness( )
Health Problems( )	Nightmares ( )	Marital/ ( ) Relationship	Family Conflict ( )
Parenting ( )	Eating Disorder ( )	Irritability ( )	Weight loss ( )

Check the number indicating the severity of your problems **described above:**(Check number)

None	Slight	Mild	Moderate	Very	Extreme	Totally Incapacitating
0	1	2	3	4	5	6

*When did your problems begin?*____

____

*What was going on in your life at that time?*____

____

____

____

____

*What seems to worsen your problems?*____

____

____

*What seems to help your problems?*____

____

____

Please briefly describe what you do on a typical weekday, starting with the time you wake up in the morning, and ending with the time you go to sleep at night. ____

____

____

____

____

____

Did this pattern change when your present difficulties begin? Yes_____ No______

*If yes, in what way?*____

____

Please briefly describe what you do on your weekends or days off. _______________________________________

____

____

____

____

____

Did this pattern change when your present difficulties begin? Yes_____ No______

*If yes, in what way?*____

____

II. Current Social Life

Describe how you are getting along with people other than your family or those with whom you live (e.g., friends, acquaintances, neighbors, co-workers), and how people generally seem to feel about you. If you are having any problems relating to people, please describe those problems.

____

____

____

____

____

____

*Have your relationships changed as a result of your current difficulties? Yes____ No_____ If yes, briefly explain the ways in which they have changed.*____

____

____

____

*How difficult is it for you to **make** friends these days?(check number)*

Very Difficult		*Somewhat Difficult*			*About Average*		*Somewhat Easy*		*Very Easy*
1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

*How difficult is it for you to **keep** friends these days?(check number)*

Very Difficult		*Somewhat Difficult*			*About Average*		*Somewhat Easy*		*Very Easy*
1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

About how many close friends do you have (people you can confide in)? _______

*How often do you talk to them?*____

*How often do you see them?*____

Rate the degree to which you generally feel relaxed and comfortable in social situations (check a number)

Very Tense & Uncomfortable		*Somewhat Tense & Uncomfortable*		*Neutral*		*Somewhat Relaxed & Comfortable*			*Very Relaxed & Comfortable*
1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

III. Current Work Life

Briefly describe your attitude and behavior at work or school. Describe any problems you are having carrying out your responsibilities or dealing with problems.

____

____

____

____

____

*Did your attitude or behavior change when your present difficulties began? Yes____ No____ If yes, in what way?*____

____

____

*What do you like about your current line of work?*____

____

____

IV. Intimate Relationships

How comfortable are you with the idea of being trusting, open, and close (vulnerable) in a love relationship. (check a number)

Very Tense & uncomfortable comfortable with closeness; very self-Protective	*Somewhat Tense & uncomfortable with comfortable self-protective*	*Neutral; Fairly self-protective but willing to be vulnerable at Times*	*Moderately Relaxed & with closeness; Pretty willing to be vulnerable*	*Extremely comfortable with closeness very willing to to be vulnerable*

1 2 3 4 5 6 7 8 9 10

***IF NOT MARRIED OR COHABITATING**: Are you currently dating any one? Yes_____ No_____ If yes,*

Are you experiencing significant difficulties in this/these dating relationship(s)? Yes_____ No______

*If yes, please describe.*____

____

____

If you are not currently dating anyone, how satisfied are you with this situation (circle a number).

Completely Dissatisfied	*Mostly Dissatisfied*	*Somewhat Dissatisfied*	*Neutral*	*Evenly Mixed Feelings*	*Somewhat Satisfied*	*Completely Satisfied*

1 2 3 4 5 6 7 8 9 10

V. Children and Family Relationships

List below each child with whom you have a parental relationship whether as a biological parent, step-parent, or other relationship.

Name: Age: Relationship:

Custody/Living arrangement:

Name: Age: Relationship:

Custody/Living arrangement:

Name: Age: Relationship:

Custody/Living arrangement:

Name: Age: Relationship:

Custody/Living arrangement:

Name: Age: Relationship:

Custody/Living arrangement:

*Do any of your children present special problems to you or your spouse/partner? Yes_____ No______ if yes, please describe.*____

____

____

____

____

____

How would you describe your present relationship with your family of origin? ____________________________

____

____

____

____

*Indicate which , if any of these relationships is currently a significant source of support or distress for you. If a relationship is problematic, describe briefly what the problem(s) seems to be.*______________________________

____

____

____

____

VI. Medical History

When was the last time you had a physical examination/check-up? ____________

Have you been treated by a physician or hospitalized in the last year? Yes____ No____ (place an X)

If yes, please specify: ____

Have there been any changes in your general health in the past year? Yes____ No____

If yes, please specify: ____ Are you taking any non-psychiatric medication or over –the-counter drugs at the present time? Yes____ No____If yes, please list:

Medication	Dosage	Frequency	Name of Provider

1.

2.

3

4.

Have been ever told you have a thyroid problem? Yes____ No____ (place an X for your response)

Have been ever told you have diabetes? Yes____No____

Do you get short of breath on mild exertion or when you lie down? Yes____ No____

Haver you ever had or have a history of: (check all that apply)

Stroke___ Anemia___ Rheumatic Fever___ Asthma___ High/Low Blood Pressure___

Heart Murmur___ Tuberculosis____ Heart Surgery____ Angina____ Ulcers___ Heart Attack___

Are you pregnant or think you may be pregnant? Yes ____ No____ N/A____

Have you ever had seizures, convulsions, or epilepsy? Yes____ No____

Do you have a prosethic heart valve? Yes____ No____

Do you have any other medical condition? Yes____ No____

If yes, specify____

Do you have any medication or food allergies? Yes____ No____

If yes, specify____

Have you ever had a major illness or injury? Yes___ No___ If yes, specify________________________________

____

____

VII. ***Psychiatric History***

Instructions: You will find below a list of questions regarding your psychiatric history. Your answers are important for your evaluation and potential treatment. Also please feel free to discuss any of these questions or your responses with your therapist or staff member. Please fill in choices completely and do not leave any questions blank.

Have you ever seen or heard anything odd or unusual that no one else could see or hear? Yes__ No__?

If you answered yes*, answer the following:*

a) *Were/are these unwanted and/or come on without warning? Yes__ No__*
b) *Are these experiences upsetting and get in the way of your life? Yes__ No__*

*Briefly describe:*____

____

Have you ever been hospitalized for an emotional or psychiatric reason? Yes___No___

If yes, how many times have you been hospitalized? ___ ___

Dates	Name of Hospital	Reason for Hospitalization	Was it helpful?
1.			
2.			
3.			

Have you received psychiatric or psychological treatment before? Yes___ No___

Dates	Name of Professional	Reason for Treatment	Was it helpful?
1.			
2.			
3.			

.

Are you taking any medication for psychiatric reasons? Yes___ No___

Medication	Dosage/Frequency	Date Started	Name of Provider_________
1.			
2.			
3.			
4			

Previously prescribed medication:

Medication	Dosage/Frequency	Date Started	Date Stopped	Name of Provider
1.				
2.				

Psychiatric History cont'd:

Additional previously prescribed medication:

Medication	*Dosage/Frequency*	*Date Started*	*Date Stopped*	*Name of Provider*
3.				

Have you ever made a suicide attempt? Yes___ No___ If yes, how many times___ ___

Approximate Date	*Exactly, what did you do to hurt yourself ?*	*Were you hospitalized*

Has anyone in your family ever received psychiatric treatment? Yes___ No___
Does anyone in your family have a history of mental illness, alcohol, or drug abuse? Yes___No___

If yes,	Family Member	List specific Psychiatric, drug or alcohol problem
1.		
2		
3		
4.		

Has anyone in your family ever made a suicide attempt? Yes___ No___ If yes, who?______________________
____

Has anyone in your family died from suicide? Yes___ No___ If yes, who?______________________________
____

Continued

VIII. <u>Alcohol & Drug Use History</u>

When did you last drink alcohol? ____________

How much did you drink? _________________

How many days per week do you drink?______ What is the most drinks in one sitting?______

What is the average amount of drinks you have had during one sitting?__________

Has alcohol ever caused a problem for you? Yes___ No___ (Place an X)

Has anyone ever told you that alcohol has caused a problem for you or complained about your drinking? Yes___ No___

Has your use of alcohol ever caused a relationship problem with anyone? Yes___ No___

Has your use of alcohol ever caused any problems at work or performing other responsibilities? Yes___ No___

Has your use of alcohol ever caused any legal problems such as being arrested or DUI? Yes___ No___

Have you ever gotten "hooked" on a prescribed medication or taken a lot more of it than you were prescribed? Yes___ No___ If yes, please list those medications:____

Have you ever been hospitalized because of a drug or alcohol problem? Yes___ No___ If yes, when and where were you hospitalized?____

Have you ever been to a detoxification program? Yes___ No___ If yes, when and where did you receive such treatment?____

Have you ever been to a drug or alcohol rehabilitation program? Yes___ No___ If yes, when and where did you receive such treatment?____

Have you ever attended a 12 step meeting such as AA, NA, Al-Anon, Al-Ateen, ACOA? Yes___ No___

Have you ever used any street drugs such as Cocaine, Marijuana, Speed (Crystal Meth), LSD, Ecstasy Other?Yes ___ No___ If yes, specify____

Has anyone ever told you that drugs has caused a problem for you or complained about your drug use? Yes___ No___

Has your use of drugs ever caused a relationship problem with anyone? Yes___ No___

Has your use of drugs ever caused any problems at work or performing other responsibilities? Yes___ No___

Have drugs ever caused any physical problems such as headaches, shakiness, stomach aches, seizures, liver damage? Yes___ No___

What is the longest period you have been drug free?________________________

When was the last time you used any drugs?______________________________

Has your use of drugs ever caused any psychological problems such as feeling depressed? Yes____ No____

Has your use of drugs ever caused any legal problems such as being arrested or DUI? Yes___ No___

School/Occupational/Relationship History:

Describe the types of jobs you've held and for reasons for leaving past jobs.

Dates	*Job Description*	*Employer*	*Reason for Leaving*

____

Have you ever made a career change ?Yes____ No____If yes, describe what led to your career changes:

____

____

____

As a child, how difficult was it to make friends? (check a umber)

Very Difficult		*Somewhat Difficult*			*About Average*		*Somewhat Easy*		*Very Easy*
1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

As a child, how difficult was it to keep friends? (circle a number)

Very Difficult		*Somewhat Difficult*			*About Average*		*Somewhat Easy*		*Very Easy*
1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

About how many close friends did you have as a child?__________

Relationship History cont'd:

Is there any common pattern that seems to take place in many of your romantic involvements?

If Married or Cohabitating:

*What year did you meet?*______________

*What did you like about him/her?*____

*How long did you know each other before getting married/living together?*_____________________________

____

Thank you ! You have completed the assessment packet. This information will be kept confidential in accord with HIPPA regulations. Please sign below to indicate that you have completed this assessment packet.

____ _________________________

Signature of patient/legal guardian ***Date***