NEW CLIENT INFORMATION

Houston Psychological Associates/ Eva S. Stubits PhD

Your cooperation in completing this questionnaire will be helpful in planning our services for you. If a question does not apply to you, fill in NA. Please answer each item carefully or ask for clarification if you do not understand an item.

Please Print

Patient Name _____
Date_____

Mailing Address
_____
Street City/St. Zip

Home Phone _____ May we leave you a message? (Please circle) Yes No

Cell Phone _____ May we leave you a message? (Please circle) Yes No

Business Phone _____ May we leave you a message? (Please circle) Yes No

May we text you? (Please circle) Yes No

Social Security #_____ Driver's Lic#_____

DOB _____ Sex: M F Relationship Status: S M W D Sep Domestic Partnership

Employer _____
Occupation_____

Employer's Address _____

E-mail Address:_____ May we email you? (Please circle) Yes No
*Please note: Email/text correspondence is not considered to be a confidential medium of communication.

Emergency Contact_____
Relationship_____

Home Phone _____Alternate # _____

List the members of your family and all others living with you.

Name	Relationship	Age

How did you hear about our facility?_____

FOR ALL PATIENTS
Name of Physician_____Phone Number_____

Date of last exam_____Known Allergies_____

Have you ever received psychiatric or psychological treatment in the past? Yes No

If so, please explain_____

Current Medications
_____

Please indicate which of the following problems pertain to you:

Nervousness	_____	Fears	_____
Sexual Problems	_____	Separation	_____
Drug Use	_____	Friends	_____
Self-Control	_____	Sleep	_____
Work	_____	Headaches	_____
Legal Matters	_____	Ambition	_____
Insomnia	_____	Loneliness	_____
Inferiority Feelings	_____	Health Issues	_____
Temper	_____	Marriage	_____
Appetite	_____	Bowel Troubles	_____
My Thoughts	_____	Shyness	_____
Depression	_____	Divorce	_____
Suicidal Thoughts	_____	Anger	_____
Alcohol Use	_____	Stress	_____
Unhappiness	_____	Tiredness	_____
Relaxation	_____	Energy	_____
Memory	_____	Concentration	_____
Making Decisions	_____	Career Choices	_____
Education	_____	Children	_____
Nightmares	_____	Being a Parent	_____
Stomach Trouble	_____		

IF CLIENT IS UNDER 18, PLEASE FILL OUT THIS SECTION.
Regarding Patient's Mother:
Name _____ Date _____

Mailing Address
_____
Street City Zip
Home Phone _____ Work Phone_____

Regarding Patient's Father:
Name _____ Date _____

Mailing Address
_____
Street City Zip
Home Phone _____ Work Phone_____

General Health

1. How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:
_____

2. 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:

_____

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

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

_____

5. Are you currently experiencing overwhelming sadness, grief, or depression? (Please circle)

No
Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or do you have any phobias? (Please circle)

No
Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? (Please circle)

No
Yes

8. Do you drink alcohol more than once a week? (Please circle) No Yes

9. How often do you engage recreational drug use? (Please circle)
Daily Weekly Monthly Infrequently Never

10. Are you currently in a romantic relationship? (Please circle)

No
Yes
If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

(1- Poor, 10-Extremely good)

11. What significance life changes or stressful events have you experienced recently?
_____
_____
_____
_____

Additional Information

1. Are you currently employed or a student? (Please circle) No Yes

If yes, what is your current employment/student situation?
_____
_____
_____

Do you enjoy your work/school? Is there anything stressful about your current work/school?
_____
_____
_____

2. Do you consider yourself to be spiritual or religious? (Please circle) No Yes

If yes, describe your faith or belief:
_____
_____
_____
_____
_____

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

_____
_____

4. What do you consider to be some of your weaknesses?

_____
_____
_____
_____
_____

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

_____
_____
_____
_____

6. Please read the office policies handout and sign the office policies agreement.

LATE CANCEL/NO SHOW POLICY

I understand that a 24-hour notice is required for canceling or rescheduling any appointment. If I am unable to give a 24 hour notice, I will be charged for the full amount of the session. I understand that Houston Psychological Associates cannot bill my insurance for a session that I did not attend. The amount due for the missed or rescheduled session is the full amount and not my copay or my percentage assigned by my insurance. I understand that Houston Psychological Associates does have a 24 hour answering service so that if I do need to cancel or reschedule my appointment, I can leave a message with the answering service.

_____

Printed Name Date

_____

Signature (Parent's signature if Patient is a minor)