Kathryn Doheny, PsyD

Licensed Clinical Psychologist

312.409.0899 | kathryn@doheny.com

307 N. Michigan Ave Suite 802, Chicago, IL 60601

CLIENT INFORMATION/CONCERNS CHECKLIST

Date: _____

Client Name: _____ Current Age: _____

Address: _____

_____

City State Zip Code

_____ _____ _____

Home Phone Cell Phone Work Phone

e-mail: _____ Can I email you at this address? Y__N___

If Married, Name of Spouse: _____

If Children, Names/Ages of Children: _____

Occupation/Employer Name: _____

If possible, please provide name/phone number of Primary Care Physician. I will inform you if coordination of care is needed. _____

How did you hear about me? _____

INSURANCE INFORMATION

Policy Holders name (yourself, your spouse, or your parent). _____

Policy Holder's Relationship to Client: _____

Policy Holder's Member ID #: _____ Policy Holder's DOB: _____
(please include letter prefix as displayed on card)

Client's DOB: _____

Group Plan: _____ Insurance Company Phone Number: _____

CONTACT PERSON IN CASE OF EMERGENCY

Name: _____ Phone:_____

Email: _____ Relationship to you: _____

INFORMATION CHECKLIST

Please review the following list of treatments you may have had in the past. Put a check next to any that apply to you and indicate the dates to the best of your recollection.

	Dates
Inpatient psychiatric hospitalization	_____
Intensive outpatient treatment	_____
(2+ days per week)	_____
Psychotherapy	_____
Outpatient Substance Abuse counseling	_____
Attending AA/NA/CA meetings	_____
Taking medication for sleep	_____

PSYCHOTROPIC MEDICATIONS

Are you taking any psychotropic medications? If so, please list including dosages. _____

_____

Psychiatrist name and phone:

_____

MEDICAL HISTORY

Please list all current medical problems you have. Be sure to include chronic conditions such as asthma, seizure disorder, arthritis, diabetes etc. _____

_____

Please list your current level of physical pain on a scale of 0-10, 0 being no pain 10 being the worst._____

HEALTH HABITS

What kinds of physical exercise do you get?_____

_____

How many times per week do you typically exercise for 20 minutes or more?_____

_____

What is your average number of hours of sleep per night?_____

HISTORY OF EVENTS

Please indicate any of the following events that may have occurred to you in the past.

_____ My parents/caretakers punished me physically as a child or teenager,

_____ My parents/caretakers were verbally harsh and critical of me as a child or teenager

_____ My parents/caretakers did not provide appropriate supervision, food, shelter or other protection

_____ My parents/caretakers were unaware of my difficulties when I was a child or teenager

_____ I experienced inappropriate sexual harassment as an adult

_____ I experienced other upsetting sexual experiences as an adult

_____ As an adult, I experienced a physical injury intentionally caused by another adult

PRESENT RELATIONSHIP

_____ I do not have a partner at present

How would you characterize your relationship with your partner (conflictual, supportive etc) _____

_____

USE OF CAFFEINE, ALCOHOL, TOBACCO AND STREET DRUGS

How much coffee, cola, tea or other sources of caffeine do you consume each day? _____

Have you ever felt the need to cut down on your drinking? Y_____ N_____

Have you ever felt annoyed by criticism of your drinking? Y_____ N_____

Have you ever felt guilty about your drinking? Y_____ N_____

Have you ever taken a morning “eye opener”? Y_____ N_____

How much beer, wine or hard liquor do you consume each week on average? _____

How much tobacco do you smoke each week? _____

Which street drugs have you used in the last 3 years? _____

LEGAL ISSUES

Are you currently suing anyone or thinking of suing anyone? If yes, please explain: _____

_____

_____

Is your reason for coming to see me related to an accident or injury? If yes, please explain; _____

_____

_____

Are you required by a court, the police or a probation or parole officer to have this appointment? _____

_____

_____

Have you had any contact with the police, courts, jails/prisons regarding a crime you were charged with?

Y_____ N_____

Are there any other legal involvements I should know about? If so, please describe: _____

_____

_____

EDUCATION/TRAINING

What is your highest level of education or specialized training? _____

_____

CHECKLIST OF CONCERNS Please mark all that apply to you.

PROBLEM AREAS:

_____ Aggression toward others
_____ Aggression toward me
_____ Career concerns, goals, choices
_____ Divorce, separation
_____ Financial or money troubles, debt, impulsive spending, low income
_____ Friendships
_____ Grieving, mourning, deaths, losses
_____ Headaches, neck or back pain
_____ Identity Issues
_____ Infidelity, affairs
_____ Interpersonal conflicts
_____ Job Stress
_____ Legal matters, charges, suits
_____ Loneliness
_____ Menstrual problems, PMS
_____ Procrastination, work problems
_____ Relationship conflict
_____ Relationship problems
_____ School problems
_____ Pain, chronic
_____ Parenting Issues
_____ Sexual issues with partner
_____ Other sexual problem
_____ Work problems, overworking, can't keep a job

EMOTIONAL CONCERNS:

_____ Feeling unsafe, even in safe situations
_____ Anger, hostility
_____ Distressing memories of the past
_____ Nightmares or upsetting dreams
_____ Suspiciousness
_____ Anxiety, nervousness
_____ Agitated
_____ Fear
_____ Obsessive thoughts
_____ Panic or anxiety attacks
_____ Phobias (please specify: _____)
_____ Shyness
_____ Tension, can't relax
_____ Attention, concentration, problems with one or both
_____ Confusion
_____ Distractibility
_____ Memory problems
_____ Depression, low mood, sadness, crying
_____ Emptiness feelings
_____ Failure feelings
_____ Fatigue, tiredness, low energy
_____ Guilt
_____ Inferiority feelings
_____ Motivation problems
_____ Mood swings
_____ Oversensitivity to rejection
_____ Oversensitivity to criticism
_____ Perfectionism
_____ Self Esteem problems
_____ Sexual drive, lack of
_____ Suicidal thoughts
_____ Feeling that others are out to get me
_____ Feeling that others are watching me
_____ Hearing voices
_____ Impulsiveness
_____ Irresponsibility
_____ Judgment problems, risk taking

BEHAVIORAL ISSUES:

_____ I have had a DUI (When? _____)
_____ Aggressive or violent thoughts or behaviors
_____ Excessive arguing
_____ Compulsive behaviors (Please specify: _____)
_____ Cutting or otherwise injuring self
_____ Decision making problems, indecision, mixed feelings, procrastinating decisions
_____ Disorganization
_____ Eating problems—overeating, undereating, vomiting
_____ Gambling
_____ Irritability
_____ Self neglect, poor self care
_____ Sleeping too much
_____ Sleep problems—too little sleep, insomnia, frequent awakenings
_____ Temper problems, self control, low frustration tolerance
_____ Weight and diet issues, or unplanned gain or loss
_____ Withdrawal, isolating

Any other concerns or issues: _____

_____

_____

Which concerns do you most want help with? _____

_____

_____