Julie Groveman, PsyD
Licensed Psychologist
(941) 548 - 6071

Patient Information Sheet

Name: ____ Date: __________________
Address:
____
____
Home Phone: ____________________ Work/Cell Phone: ______________________________
E-mail____
Where is the best place to leave a message? ____
Date of Birth: __________________ Age: __________ Marital Status: ______________________
Age of Spouse/Partner?____
Social Security Number: ____
Emergency Contact: ________________________________ Phone: _______________________
Relationship to you: ____
Where were you born? ____
What is your ethnicity? ______________________
Present religious identification? ________________

Health

Name of Physician: ___________________________ Phone: _______________________________
(**I will not contact this provider without your written permission)**
Date of Last Physical Exam: ____
Medications: ____
Significant Medical History (chronic conditions, accidents, major illnesses or surgeries):
____

In general, would you say your current physical health is:
___Excellent 2. ___Very good 3. ___ Good 4. ___Fair 5. ___Poor

In general, would you say your physical health throughout your life has been:
1. ___Excellent 2. ___ Very good 3. ___ Good 4. ___ Fair 5. ___Poor

At present, do you have any disabilities? 1. ____No 2. ____Yes

IF YES, Type of Disability Age of Onset Type of Disability Age of Onset
_______________ _____________ _______________ _____________
_______________ _____________ _______________ _____________

At present, do you have any serious illnesses? 1.____ No 2. ____Yes
IF YES,
Type of Illness Age of Onset Type of Illness Age of Onset
_______________ ___________ _______________ ___________
_______________ ___________ _______________ ___________

Have you ever had any serious illnesses or disabilities 1.____No 2. ____Yes
IF YES,
Type of Illness or Disability Age of Onset Type of Illness or Disability Age of Onset
_____________________ ___________ _____________________ ___________

Have you had any medical problems that required surgery? 1.____No 2.____Yes

IF YES,

Type of Surgery Age of Onset Type of Surgery Age of Onset
_________________ ___________ _________________ __________

Have you had any serious accidents? 1.____ No 2. ____Yes
IF YES,
Type of Accident Age of Onset Type of Accident Age of Onset
_________________ ___________ _________________ __________

Are you HIV positive? 1. ______No 2. _____ Yes 3. _____Do not know

Are you currently under a physician's care? 1. _____ No 2. ____ Yes

Previous Psychological Treatment
Type/Length of Treatment:____
____
Provider's Name and Address:____
(**I will not contact this provider without your written permission)**
Have you ever been hospitalized for psychiatric reasons? If so, list dates and locations:
____
Are you currently taking any medication? If yes, please specify
____
Have you ever had suicidal thoughts?
1. ____Never 2. ____Sometimes 3. ____ Frequently

Have you ever made a suicide attempt?
1. ____No 2. ____ Yes, please specify number of attempts __________________
If yes, when was your last suicide attempt?________________________

Are you using non-prescriptive drugs? 1. ____Yes 2. ____No

If yes, please specify type of drug and frequency of use. *(Use the back of this page if necessary)*:
Type Frequency Type Frequency
_____________ ______________ ________________ ________________

Do you drink alcohol? 1. ____Yes 2. ____No

If yes, please specify amount and frequency: Amount ___________ Frequency___________

Do you ever wonder if you have a problem with drugs of alcohol?
1. ____No 2. ____Yes 3. ____Uncertain

Have you ever been treated for a drug or alcohol problem?
1. ___No 2. ____Yes *(specify)* ____

Do you binge on food, purge, or use laxatives?
1.____No 2. ____Yes *(specify frequency)* ____

Do you currently smoke cigarettes? 1.____No 2. ____Yes *(specify frequency)* ______________

Are you now in a 12 step program? (e.g., A.A., N.A., O.A., S.A., S.I.A.)

1.____No 2. ____Yes *(specify program)* ______________________________________

Have you ever been in a 12 step program? (e.g., A.A., N.A., O.A., S.A., S.I.A.)
1.____No 2. ____Yes *(specify program)*______________________________________

I look forward to the future with hope and enthusiasm. 1. ______True 2. ______False

Who referred you to Dr. Julie Groveman?
____

Education and Employment Information
Education:____
In what occupation are you currently employed?________________________________
What occupation were you trained for?______________________________________
Are you presently employed?____
Employer: ____
May I contact you at work? ____ Yes ____ No
Person Responsible for Payment (if other than self?)____________________________
Address: ____
City/State/Zip: ____
Home Phone: __________________________________ Work Phone: ________________
If Patient is a minor, Legal Guardian's Name: ____________________________________
Guardian's Address and Phone Number: _______________________________________

Family Information
IF PRESENTLY MARRIED, LIVING WITH A PARTNER, OR IN A COMMITTED RELATIONSHIP COMPLETE THE FOLLOWING QUESTIONS:

When were you married/or did you begin living together/or did you consider your relationship a committed one? Month _______ Day _______ Year ________

Age of spouse/partner: ____________ *(in years)*

What is your spouse's/ partners occupation? ______________________________*(specify)*
Is spouse/partner currently employed?

How many people including family members are living in your household, include spouse, children *(male or female)*,partner, roommates, and specify relationship.

Age	Relationship	Age	Relationship
_____	_____________	_____	____________
_____	_____________	_____	____________
_____	_____________	_____	____________

My relationships with family members *(check one)*
1. ___ Provide extensive emotional support
2. ___ Provide an average amount of emotional support with occasional conflict
3. ___ Provide less than adequate emotional support with frequent conflict
4. ___ Do not provide emotion support
5. ___ No contact with family

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My relationships with friends *(check one)*
1. ___ Provide extensive emotional support
2. ___ Provide an average amount of emotional support with occasional conflict
3. ___ Provide less than adequate emotional support with frequent conflict
4. ___ Do not provide emotion support
5. ___ No friends

Do you have siblings? *(If appropriate, include step siblings and half siblings)* 1. ___ No 2. ___Yes

If one or more siblings, please complete following:

Sex Age Sex Age Sex Age
____ ____ ____ ____ ____ ____
____ ____ ____ ____ ____ ____
____ ____ ____ ____ ____ ____

Please describe any medical or emotional problems of your parents or siblings:
____
____
____
____

Where was your father born? ____

Is your father: 1. ___Living 2. ____Deceased

If he deceased, how old were you when he died?
____

What is/was your father's main occupation?
____

What was your father's highest level of education?____

Where was your mother born?____________
____

Is your mother: 1. ____Living 2. ____Deceased

If she is deceased, how old were you when she died? ____________________________________

What is/was your mother's main occupation?____

What was your mother's highest level of education? ____________________________________

Have your parents ever been separated? 1. ______ No 2. ______Yes

Have your parents ever been divorced? 1. ______ No 2. ______Yes

If yes, how old were you at the time of the separation or divorce?____________________________________

Current Concerns

Please check all reasons you are seeking counseling? *(You may check more than one)*

___ Anxiety
___ Difficulty adjusting to life transition
___ Confusion about self-image, goals, etc.
___ Decreased Performance at work, home or school
___ Depression
___ Grief/loss
___ Health status of myself
___ Health status of someone you care about
___ Hormonal concerns
___ Infertility issues
___ Memory problems
___ Relationship problems
___ Planning the future
___ Concerns about sexual abuse
___ Concerns about physical abuse
___ Aftermath of a trauma *(specify)*____
___ Anorexia
___ Bulimia
___ Overeater
___ Concerns About alcohol use/abuse ___ self ___ other ___ past ___ present
___ Other *(specify)*_______ ___ ____

Briefly describe your reasons for seeking help at this time: ______________________________________
____
____
____
____
____
____
____
____
____
____
____

Signature ____ Date __________________________