Post and Associates

Psychological Assessment · Consulting

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Today's Date ____________

General Information

Patient's Name ____ DOB _____________

Address ____

____

Phone (h) ___________________ (w) ____________________ (c)_____________________

Sex __________ Age _________ SSN# ______________________

Insurance Carrier______________________ Insurance/VA# ________________________

Primary Care Medical Provider ___________________________ Tel. _________________

Family History

Current relationship status: Single/Married/Divorced/Separated/Widowed/Other ______

How many times have you been married? ___________________

How did each marriage end? ____

Do you have any children? Yes/no If so, please list their ages _______________________

Do you have any siblings? Yes/no If so, please list their ages ________________________

Please list any known family history of medical conditions, psychiatric conditions (diagnosed or suspected), substance abuse, and behavioral conditions (impulsiveness, gambling, etc.):

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Educational History

Highest Grade Completed ___________ High-school Diploma yes/no GED yes/no

Have you completed any further education or trade school? Yes/no If so, please describe:

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Military History

Were you ever in the military? Yes/no If so, what branch?___________________________

Highest Rank Achieved_______________ Rank at Discharge ________________________

Type of Discharge ____

Occupational History

Please list types of jobs you have held: ____

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Are you currently employed? Yes/no If yes, what is your current position and how long have you worked there? If not, when was the last time you worked and what was your position? ____

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Legal History

List any legal matter you have been involved with including charges, arrests, jail time, and DUIs____

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Medical History

Medical Conditions

Please list all diagnosed medical conditions, significant illnesses, surgeries, significant injuries, head injuries:

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____

____

____

____

Allergies? ____

Current Medications/Herbals/Supplements:

____________dose ___________
____________dose ___________
____________dose ___________
____________dose ___________
____________dose ___________
____________dose ___________

Past medications, etc.:

____
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____
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Substance Use History

How often do you drink alcohol? ______________________________

How often do you use drugs? ______________________________

Do you smoke cigarettes or use tobacco? If so, how much? ______________

Have you ever been treated for drug/alcohol problems? Yes / No

Psychiatric History

Psychiatric Diagnoses: **Date:** **Diagnosing Doctor:**

Psychotherapy or Counseling: **Date:** **Clinician:**

Current Problem

Reason for today's visit: ____

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History of this problem: ____

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Please describe anything else you think may be relevant (i.e. school problems, history of abuse, etc.)

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