

NEW PATIENT CLIENT INFORMATION FORM

Courtney Schuneman, Psy.D., PLLC
7624 N. La Cholla Blvd., Tucson, AZ 85741
(520) 477-2273 CARE@Dr-Courtney.com

Please fill out this biographical information form as completely as possible as it will help our work together. Information is confidential as outlined in the Consent to Treatment form and the HIPAA Privacy Practices form. Please write clearly and email it or bring it with you to the first session.

Name: _____ Male / Female / Other Today's Date: _____

Date and Place of Birth _____ Age: _____

Address: _____

Phone Number _____ May I leave messages? YES/NO Text? YES/NO

E-mail (if you want to use this type of communication) _____

Emergency Contact (Name, Phone, Relationship): _____

How did you hear about me? _____

Are you enrolled in Medicare? YES/NO Arizona AHCCCS? YES/NO **Please understand you cannot submit receipts for reimbursement to either Medicare or Medicaid/AHCCCS**

What brings you to therapy? (Describe concerns, when did they start, how do they affect you):

Current Grade/Degree: _____ Current School: _____

Do/did you enjoy school? YES / SOMEWHAT / NO

Learning/Developmental Issues: _____

Occupation (former, if retired): _____

Do/did you enjoy your work? YES / SOMEWHAT / NO

FAMILY & RELATIONSHIPS:

Current relationship status/living situation: _____

Partner's name/age/occupation: _____ Years together: _____

How would you rate this relationship on a scale of 0 (Disappointing) to 10 (Excellent)? _____

Past important relationships (first names, years together, and statement about the nature of the relationship(s), i.e., friendly, distant, physically/emotionally abusive, loving, hostile):

Children: (biological/step/names/ages & brief statement about your relationship with the person)

1. _____
2. _____
3. _____

Parents/Stepparents (Name/age or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship):

Father: _____

Mother: _____

Stepparents: _____

Siblings (name/age/brief statement about the relationship):

1. _____
2. _____
3. _____

MEDICAL & MENTAL HEALTH:

Medical doctor(s) (name/phone): _____

Past/Present medical issues (major medical problems, surgeries, hospitalizations, accidents, allergies, pregnancies, sleep issues, current pain level on a scale of 1-10 (none to unbearable pain):

How would you rate your current physical health 0 (poor) to 10 (excellent)? _____

Medications and supplements you are presently taking and for what issue: _____

Family medical history (family member's physical health issues: i.e. cancer, thyroid issues etc.):

Past/present psychotherapy (please specify approximate beginning and end dates; estimated # of sessions; name of therapist; initial reason for therapy; and a brief description of the relationship, how helpful it was, and how/why it ended):

Please describe substance use- past/currently and how much?

Caffeine: _____ Alcohol (type): _____

Nicotine Use (type): _____ Drug Use (type): _____

Any other addictions (gambling, food, pornography, etc)? _____

Suicide attempts, violent behavior, self-harm behavior/cutting, disordered eating (binge-eating, self-inflicted vomiting, extreme diets), (describe: ages, reasons, circumstances, etc.):

Do you currently have thoughts or plan to hurt yourself or anyone else? _____

Family history of alcoholism, mental illness, or violence (including suicide thoughts/attempts, depression, psychiatric hospitalizations, abuse, etc.):

Describe your childhood, in general (If your parents divorced- how old were you? _____ Please describe relationships with parents, siblings, others; school, relocations, any school issues, behavioral problems, abusive/alcoholic caregivers:

Have you experienced/witnessed any traumatic experiences (deaths of loved ones, losses, serious accidents, sexual assault/rape, military trauma, near death experiences, etc.)? _____

ADDITIONAL INFORMATION:

Estimate how many hours per day you spend using electronics: Talking on the phone: _____

Social media (Facebook, Insta, Tiktok etc.): _____ YouTube: _____ Texting: _____ Browsing: _____

Watching TV/movies: _____ Gaming/Video Games: _____ Other: _____

Do you feel your technology use is balanced and healthy or could it use improvement? _____

What is important for me to know about your sexuality and gender identity?

Legal issues: Are you involved in any current or pending civil or criminal litigations, lawsuits, child protective services investigations or divorce or custody disputes? (please explain):

Financial stress: Any bankruptcy, financial stressors, gambling issues, or excessive spending?

Social Support: Do you have a supportive environment/positive friendships and family etc.?

Religion: religious, non-practicing, spiritual, agnostic, atheist etc.- please describe:

What gives you the most joy or pleasure in your life?

What are your hopes or dreams for the future?

List your past/current hobbies? Pets (names/type of animal?)

I certify that the above information is accurate to the best of my knowledge:

Signature of Guardian/Client

Client's name

Date