Torborg & Kobienia
Psychological Services, LLC

Date: _____

NEW PATIENT INFORMATION FORM

Instructions: Please fill out this form as completely and openly as possible. Your personal Information will be held in **strict confidence** within legal limits.

Basic Information:

Name: _____ Preferred Name:_____ Age: _____ Date of Birth: _____

Home Phone: _____ Cell: _____ Work Phone: _____

E-mail:_____

***Ethnic Origin*:**

_____ African American _____Asian _____Caucasian _____Hispanic _____Native American _____Other

Relationship Status:

_____Single _____Married _____Separated/Divorced _____Widowed _____Remarried _____Partnered

Religion:

_____Catholic _____Christian _____Jewish _____Lutheran _____Mormon _____Islamic _____No Religion _____Other

Areas of Concern: Please check the main areas of concern you would like to address in psychotherapy.

☐ Anxious Feelings	☐ Feeling Depressed	☐ Relationship Difficulties	☐ Drug Problems
☐ Problems Adjusting	☐ Work/Career Concerns	☐ Difficulties with School	☐ Attention Difficulty
☐ Anger Issues	☐ Alcohol Problems	☐ Memory Difficulties	☐ Eating Disorder
☐ Chronic Pain	☐ Grief & Loss	☐ Sleep Difficulties	☐ Sexual Issues
☐ Suicide Thoughts	☐ Recovery from Abuse	☐ Traumatic Incident	☐ Stress Overload
☐ Financial Distress	☐ Panic Attacks	☐ Obsessive Compulsive Disorder	☐ Bipolar Disorder

☐ Problem Behaviors, specify:_____

☐ Other Issues: _____

Previous Mental Health Care Received: Please indicate below what the **treatment** was for (e.g. depression, anxiety, etc.), the **approximate start date** (It's ok to estimate), **name of the treatment facility or provider**, **type of care** you received (e.g. individual therapy, family /couples therapy, hospitalization, etc.), **outcome** of treatment (poor, fair, good, excellent, etc.), and **how long** treatment lasted.

Treatment	Date	Facility/Provider	Type of Care	Outcome	Duration

Psychosocial History:

Current Family Information:

1) If you are currently married or partnered, how long have you been married/partnered? _____ years
2) If so, what is your spouse's/partner's name? _____ his/her age _____
3) If you are separated, divorced or widowed, how long has that been? _____ years
4) How many times have you been married? _____ times
5) If you have children, please complete the following. Feel free to add another page if needed.

Child's Name	Age	Child lives with me Yes	No	If "no" who does she/he live with and where?
1.				
2.				
3.				
4.				
5.				

Any miscarriages or stillbirths? Yes _____ No _____ When? _____

In addition to children and/or spouse listed above, *who else lives in your home*?

Person's Name	Age	Relationship to You

Current Life Situation:

In the following areas of life, please check all that apply (ok to check more than one option in each category). Feel free to add comments as well.

1. ***Current Family Life:*** ☐ Close ☐ Conflicted ☐ Supportive ☐ Distant ☐ Neutral

Comments: _____

_____

2. ***Circle of Friends:*** ☐ Many ☐ Few ☐ None ☐ Supportive ☐ Draining ☐ Changeable ☐ Other

Comments:_____

_____

3. ***Significant/Primary Relationship:*** ☐ Close ☐ Conflicted ☐ Supportive ☐ Distant ☐ Neutral

Comments:_____

_____

4. ***Work Setting:*** ☐ Challenging ☐ Stressful ☐ Supportive ☐ Rewarding ☐ Unhealthy ☐ N/A ☐ Other

Comments:

_____

5. Employment:

- Are you currently employed? ☐ Yes ☐ No
- If yes, where?

  _____
- What is your job title?

  _____
- If not employed, are you (check all that apply) ☐ Actively looking for work ☐ Disabled ☐ Terminated ☐ Choosing not to be employed ☐ Laid-off ☐ Needing Childcare ☐ Attending school ☐ Retired ☐ Other
- Any history of difficulties with employment? ☐ Yes ☐ No, If yes, please explain:

  _____

  _____

  _____

6. ***Hobbies and leisure activities:*** Please list any hobbies and leisure activities you enjoy:

_____

_____

_____

7. Education:

- Years of schooling (0 to 16+) _____
- Diploma or highest degree received: _____
- Any history of learning difficulties: ☐ Yes ☐ No

- If so, please check all areas of difficulty you have experienced in the area of learning. ☐ Concentration ☐ Hearing ☐ Listening ☐ Reading ☐ Writing ☐ Remembering ☐ Other Comments: _____

8. ***Cultural Factors:*** ☐ Challenging ☐ Stressful ☐ Supportive ☐ Rewarding ☐ Unhealthy ☐ N/A ☐ Other
Comments: _____
_____

9. Current Living Arrangements:

- Please describe your current living situation, (e.g. own home, rent an apartment, living with friends/family, retirement community, group home, homeless in a shelter, etc.) _____
_____
- Are you satisfied with your living situation? ☐ Yes ☐ No
If no, please explain:_____

10. Military Service:

- Have you served in the military? ☐ Yes ☐ No
- If yes, when? From _____ To _____
- What branch of service? _____
- How would you describe the experience? ☐ Mostly positive ☐ Mostly negative ☐ Positive & Negative ☐ Neutral
- Please explain: _____
_____

11. Anything else you see as significant about your current life situation:
_____
_____

Medical Overview: (Please add another page if you need more space).

1. Please list current and past **medical conditions** and the approximate date you were diagnosed.

Condition(s)	Date of Diagnosis

2. Please list all current **medication(s)**, dosage and approximate time you started on the medication.

Medication	Dosage	Purpose	Approx. time started

3. Please list any **allergies** (seasonal, environmental, medication, food, etc.), type of reactions you have (rash, nausea, trouble breathing, etc.), level of severity (mild, moderate or severe) and the approximate time the allergy began.

Allergy	Type of Reaction	Severity	Approx. Date of Onset

4. Are there any **medical conditions in your family-of-origin?** ☐ Yes☐ No
If yes, please describe:_____

Primary Care Clinic:

☐ CentraCare ☐ St. Cloud Medical Group ☐ Williams Integracare ☐ Health Partners ☐ Other _____

Primary Care Provider: _____Psychiatric Provider:_____

Self and Family Psychiatric History: For each condition listed below, please identify yourself or biological relative who has experienced the condition, any known treatment (i.e. in-patient, out-patient, none), and the outcome of treatment (i.e. poor, fair, good).

Condition	Self/Relative	Treatment	Outcome
Depression			
Anxiety			
Alcohol or Drug Issues			
Eating Disorder			
Suicide Attempt			
Bi-Polar Disorder			
ADHD			
Other (name)			

Family Of Origin History:

1. Please list the member(s) in your ***family of origin***. Include parents, step-parents, siblings, and step-siblings. Indicate approximate age (or if deceased, approximate year of death), relationship to you (mother, father, sister brother, stepmother, stepfather, stepbrother, stepsister, etc.) and relationship with you (check all that apply).

Name of Family Member	Age (or Year of Death)	Relationship to You	Quality of Relationship with You (check all that apply)
			☐ Healthy ☐ Loving ☐ Supportive ☐ Neutral ☐ Distant ☐ Conflicted ☐ Abusive ☐ Other
			☐ Healthy ☐ Loving ☐ Supportive ☐ Neutral ☐ Distant ☐ Conflicted ☐ Abusive ☐ Other
			☐ Healthy ☐ Loving ☐ Supportive ☐ Neutral ☐ Distant ☐ Conflicted ☐ Abusive ☐ Other
			☐ Healthy ☐ Loving ☐ Supportive ☐ Neutral ☐ Distant ☐ Conflicted ☐ Abusive ☐ Other
			☐ Healthy ☐ Loving ☐ Supportive ☐ Neutral ☐ Distant ☐ Conflicted ☐ Abusive ☐ Other
			☐ Healthy ☐ Loving ☐ Supportive ☐ Neutral ☐ Distant ☐ Conflicted ☐ Abusive ☐ Other
			☐ Healthy ☐ Loving ☐ Supportive ☐ Neutral ☐ Distant ☐ Conflicted ☐ Abusive ☐ Other
			☐ Healthy ☐ Loving ☐ Supportive ☐ Neutral ☐ Distant ☐ Conflicted ☐ Abusive ☐ Other
			☐ Healthy ☐ Loving ☐ Supportive ☐ Neutral ☐ Distant ☐ Conflicted ☐ Abusive ☐ Other
			☐ Healthy ☐ Loving ☐ Supportive ☐ Neutral ☐ Distant ☐ Conflicted ☐ Abusive ☐ Other

2. Were your parents separated or divorced? ☐ Yes ☐ No, If yes, how old were you when that occurred? ________
3. Describe the relationship between your mother and father (check all that apply). ☐ Healthy ☐ Loving ☐ Supportive ☐ Neutral ☐ Distant ☐ Conflicted ☐ Abusive ☐ Other
4. Significant family information/events:

____
____
____
____

Situational Stresses:

1) Are there any recent or current situational stresses in your life causing significant difficulty? ☐ Yes ☐ No
If so, please name: _____

2) Other Critical Stress Factors:

☐ Family problems	☐ Legal/financial problems	☐ Health problems
☐ Relational problems	☐ Drug/Alcohol problems	☐ Disabilities
☐ Spousal problems	☐ Job-related problems	☐ Trauma
☐ Divorce/Separation	☐ School problems	☐ Abuse issues (emotional, physical, sexual)
☐ Parent/child problems	☐ Spiritual concerns	

3) In reaction to the above identified stresses, are you experiencing any of the following? (Check all that apply)

☐ Feeling overwhelmed	☐ Feeling anxious	☐ Feeling depressed
☐ Difficulty deciding	☐ Trouble coping	☐ Struggling to managing feelings
☐ Engaging in behavior that is not good for you		☐ Difficulties in relationship

Review of Symptoms: The following is a list of questions about things you may be experiencing.

Mood:

Part I

1. Do you have a history of depression or are you currently feeling depressed? ☐ Yes ☐ No

2. If yes, does your depression come and go? ☐ Yes ☐ No
If **yes**, how many times has it done so? _____
If **no**, has it been there continuously most of your life? ☐ Yes ☐ No

3. How old were you when you were first depressed? _____

4. Does the depression get worse in the winter? ☐ Yes ☐ No

5. If you are **female**, is your depression (or anxiety/irritability) worse **before your periods?** ☐ Yes ☐ No

6. If you are **female**, are you going through your change of life (**menopause**)? ☐ Yes ☐ No
If **yes**, has your depression gotten worse in the midst of this change? ☐ Yes ☐ No

Please check the symptoms of depression you are **currently** experiencing

☐ Depressed mood	☐ Hopeless feeling	☐ Trouble sleeping
☐ Sleeping too much	☐ Poor concentration	☐ Memory impaired
☐ Little or no energy	☐ Low motivation	☐ Irritability
☐ Loss of appetite	☐ Eating too much	☐ Recent weight loss
☐ Moving slowly	☐ Hard to enjoy things	☐ Feeling agitated or stirred-up
☐ Feeing worthless	☐ Excessive guilt	☐ Thoughts of wanting to die
☐ Withdrawing from others		

Part 2

1. Has there ever been a period of time when you were not your usual self? (Check all that apply)

☐ Felt extremely good or hyper	☐ Had trouble concentrating
☐ Shouted at people or started arguments	☐ Had much more energy
☐ Felt incredibly self-confident	☐ Were much more active or did more things
☐ Got much less sleep and didn't miss it	☐ Were much more social or outgoing
☐ Couldn't slow your mind down	☐ Spent more money than you could afford
☐ Did things others thought were excessive, foolish or risky	☐ Talking more loudly or faster than usual
☐ Felt sudden changes in mood	☐ Felt driven to do fun things
☐ Had trouble sitting still	☐ Felt more irritable and angry
☐ Hard time getting to sleep	

Part 3

1. Have you had a sudden attack of intense fear or discomfort that included: (Check all that apply)

☐ Pounding/racing heart	☐ Chest pain/discomfort	☐ Feel like you are dying
☐ Sweating	☐ Sick to your stomach	☐ Numbness or tingling
☐ Trembling/shaking	☐ Feeling like things are not real	☐ Feeling of choking
☐ Feel like you're losing control	☐ Lightheadedness	☐ Chills
☐ Trouble breathing	☐ Feeling like you're not real	

2. Do you avoid going places because you are worried you may have an anxiety attack? ☐ Yes ☐ No
3. Do you have to force yourself to go places that you would prefer to avoid because of this worry ☐ Yes ☐ No

Part 4

Please check all of the following that apply:

☐ Frequent nervousness or anxiousness	☐ Feeling restless or keyed up
☐ Frequent worry about a number of things	☐ Fearful about going out and about
☐ Anxious or uncomfortable about being in a social setting	☐ Headaches
☐ Muscle tension /pain	☐ Trouble Sleeping
☐ Upset stomach	☐ Thoughts going round and round
☐ Pictures in your mind that play over and over	☐ Feeling driven to check things over and over

☐ Being especially afraid of certain things, what specifically? _____

☐ Feeling driven to do certain things over and over to feel less nervous? What especially: _____

_____

Attention/Concentration/Memory:

1. Do you have difficulty paying attention and concentrating at work, school, or home? ☐ Yes ☐ No
2. Is it hard for you to sit still for more than ½ hour at a time? ☐ Yes ☐ No
   If **yes,** have you had these problems since you were a child? ☐ Yes ☐ No
3. Have you ever been diagnosed with Attention Deficit/Hyperactivity Disorder? ☐ Yes ☐ No
   If **yes**, were you treated with medication? ☐ Yes ☐ No
   If **yes,** What medicines? _____
4. Do you have trouble with your memory? ☐ Yes ☐ No
   If **yes,** please explain _____
   If **yes**, how long have you had trouble? _____

Perception and Beliefs:

1. Do you hear things other don't hear (auditory hallucinations)? ☐ Yes ☐ No
2. Do you see things other don't see (visual hallucinations)? ☐ Yes ☐ No
3. Do you believe that others are spying on you or are out to get you? ☐ Yes ☐ No
4. Do you think that others are talking about you? ☐ Yes ☐ No
5. Do you think that someone is putting thoughts into your head? ☐ Yes ☐ No
6. Do you believe you have special powers? ☐ Yes ☐ No
7. Do you think that you receive special messages through the TV or radio? ☐ Yes ☐ No

Trauma:

1) Have you ever been sexually or physically abused or assaulted, or been the victim of another violent crime? ☐ Yes ☐ No
2) Have you ever witnessed someone else being sexually or physically abused? ☐ Yes ☐ No
3) Have you ever been in an accident, fire, or natural disaster where you or someone else was seriously injured or killed? ☐ Yes ☐ No

If you answered **yes** to one of the above, please check all of the following that apply:

☐ Sudden memories of the event	☐ Upsetting memories of the event	☐ Nightmares
☐ Feeling physical reactions to reminders	☐ Feeling distress about reminders	☐ Avoiding activities related to event
☐ Avoiding places related to event	☐ Avoiding thoughts and feelings	☐ Loss of interest in life's activities
☐ Detached or numb feeling	☐ Inability to recall details of the experience	☐ Sense of limited future
☐ Difficulty falling or staying asleep	☐ Irritability or outburst of anger	☐ Difficulty concentrating
☐ Being overly alert to danger	☐ Feeling jumpy or easily startled	☐ Having difficulties in relationship

Other Concerns:

1.	Are you comfortable with your current body weight?	☐ Yes	☐ No
2.	Do you or have your ever tried to lose weight by eating very little or fasting?	☐ Yes	☐ No
3.	Have you ever used laxatives, diuretics, or made yourself throw up in order to lose weight?	☐ Yes	☐ No
4.	Are there times when you eat unusually large amounts of food at one time?	☐ Yes	☐ No
5.	Do you experience outbursts of anger?	☐ Yes	☐ No
6.	If so, how often: _____ daily _____ Weekly _____Monthly _____Occasionally		
7.	At times, do you yell, shout or name call?	☐ Yes	☐ No
8.	Have you ever been physically violent?	☐ Yes	☐ No
9.	Do you gamble?	☐ Yes	☐ No
10.	If so, how often? _____ daily _____ Weekly _____Monthly _____Occasionally		
11.	Have you ever lost more money than you could comfortably afford?	☐ Yes	☐ No
12.	Are you happy/comfortable with your sex life?	☐ Yes	☐ No
13.	Any difficulties with sexual performance?	☐ Yes	☐ No
14.	Do you use pornography?	☐ Yes	☐ No
15.	Do you engage in any sexual behavior that concerns you?	☐ Yes	☐ No

Impairment:

Overall, how much difficulty do the concerns identified above cause you in the following areas of life?

(0 = none, 1 = mild, 2 = mild/moderate, 3 = moderate, 4 = moderate/severe, 5 = severe)

_____ Work _____Finances _____Leisure _____School

_____ Parenting _____ Self-care _____Primary Relationship _____ Social Life

_____Other, specify: _____

Comments:_____

_____

Risk Assessment:

1.	Have you ever had thoughts of ending your life?	☐ Yes	☐ No
	If **yes**, have you attempted to take your life?	☐ Yes	☐ No
	If **yes,** how many times? _____		
	If **yes**, please list what you attempted to do and when: _____		
	_____		
2.	If you've had suicidal thoughts, but haven't attempted, what has stopped you? _____		
	_____		
3.	Do you have suicidal thoughts now?	☐ Yes	☐ No
4.	Do you have thoughts of harming yourself?	☐ Yes	☐ No
5.	Have you harmed yourself?	☐ Yes	☐ No
6.	Do you have thoughts of harming someone else?	☐ Yes	☐ No
7.	Have you harmed someone else?	☐ Yes	☐ No

Legal Issues:

1. Are you currently involved in any legal difficulties (i.e. DWI, divorce, lawsuit, custody dispute, felony, probation, traffic, etc.) ☐ Yes ☐ No
   If yes, briefly describe your difficulties: _____
   _____
2. Have you had any other legal problems in the past? ☐ Yes ☐ No
   If **yes**, please briefly describe your difficulties _____
   _____

Substance Use:

1. Do you drink alcohol? ☐ Yes ☐ No
   If **yes**, how often? _____
   If **yes,** approximately how much each time? _____
   If **no,** have you drank alcohol in the past? ☐ Yes ☐ No
2. Do you consume caffeinated beverages? ☐ Yes ☐ No
   If **yes,** what beverage, how much, and how often? _____
   _____
3. Do you use tobacco? ☐ Yes ☐ No
   If **yes,** what kind (cigarettes, chew, etc.)? _____
   If **yes,** how often? _____
   If **yes,** would you like information on how to quit? ☐ Yes ☐ No
4. Do you use street drugs? ☐ Yes ☐ No
   If **yes,** what kind? _____
   If **yes,** how often? _____
   If **no,** have you used street drugs in the past? ☐ Yes ☐ No
5. Have you ever misused prescription medications? (e.g. pain, anxiety, or sleeping pills[1]) ☐ Yes ☐ No
6. Has alcohol or drugs caused any problems for you in the past or present? ☐ Yes ☐ No
   If **yes,** what kind of problems? _____
7. Have you ever been in chemical dependency treatment? ☐ Yes ☐ No
   If **yes,** when? _____
8. Is there a history of any of the above chemical use issues in your family of origin? ☐ Yes ☐ No
   If yes, please describe:_____

General Comments:

_____

_____

_____

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