

# KESSLER PSYCHOLOGICAL SERVICES, LLC.

DATE \_\_\_\_\_

NAME \_\_\_\_\_ SS# \_\_\_\_\_

ADDRESS \_\_\_\_\_ ZIP CODE \_\_\_\_\_

DOB \_\_\_\_\_ AGE \_\_\_\_\_ HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

**CURRENT FAMILY INFORMATION:**

NAME	RELATIONSHIP	AGE	SEX	OCCUPATION
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**DEVELOPMENTAL HISTORY:**

PLEASE LIST SIBLINGS, INCLUDING YOURSELF, AND THE BIRTH ORDER IN FAMILY OF ORIGIN:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
 4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

PLEASE CHECK ANY OF THE FOLLOWING WHICH WERE PROBLEMS IN THE **FAMILY IN WHICH YOU WERE RAISED:**

- |                                                                                 |                                           |                                              |
|---------------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> FREQUENT MOVES                                         | <input type="checkbox"/> ALCOHOL/DRUG     | <input type="checkbox"/> DEATH FAMILY MEMBER |
| <input type="checkbox"/> PARENTS DIVORCE                                        | <input type="checkbox"/> LEGAL PROBLEMS   | <input type="checkbox"/> ABUSE/NEGLECT       |
| <input type="checkbox"/> PARENTS REMARRIAGE                                     | <input type="checkbox"/> PARENT CONFLICT  | <input type="checkbox"/> SEXUAL ABUSE        |
| <input type="checkbox"/> PARENTS SEPARATED                                      | <input type="checkbox"/> PARENT JOB LOSS  | <input type="checkbox"/> DOMESTIC VIOLENCE   |
| <input type="checkbox"/> FAMILY ILLNESS                                         | <input type="checkbox"/> FINANCIAL STRESS | <input type="checkbox"/> EMOTIONAL PROBLEMS  |
| <input type="checkbox"/> LOSS OF JOB                                            | <input type="checkbox"/> PERSONAL ILLNESS | <input type="checkbox"/> LEARNING PROBLEMS   |
| OTHER _____                                                                     |                                           |                                              |
| <input type="checkbox"/> OTHER ISSUE (WISH TO DISCUSS WITH COUNSELOR IN PERSON) |                                           |                                              |

INFORMATION ABOUT **YOUR DEVELOPMENT UP TO AGE 18.** MAY HELP CLARIFY A PROBLEM YOU MIGHT PRESENTLY BE HAVING. PLEASE PLACE A CHECK MARK IN THE BLANK FOR THOSE THAT APPLY TO YOU.

- |                                              |                                               |                                               |
|----------------------------------------------|-----------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> PREMATURE BIRTH     | <input type="checkbox"/> AVOIDING OTHERS      | <input type="checkbox"/> BEDWETTING           |
| <input type="checkbox"/> BIRTH DEFECT        | <input type="checkbox"/> NERVOUS              | <input type="checkbox"/> FIDGETY / RESTLESS   |
| <input type="checkbox"/> HEAD INJURY         | <input type="checkbox"/> ABUSE / NEGLECT      | <input type="checkbox"/> EATING DISORDERS     |
| <input type="checkbox"/> TALKING             | <input type="checkbox"/> REFUSING TO TALK     | <input type="checkbox"/> BAD DREAMS           |
| <input type="checkbox"/> LEARNING PROBLEMS   | <input type="checkbox"/> SPEECH PROBLEMS      | <input type="checkbox"/> SLEEPWALKING         |
| <input type="checkbox"/> POOR COORDINATION   | <input type="checkbox"/> FREQUENT EAR PROBLEM | <input type="checkbox"/> SCHOOL BEHAVIOR      |
| <input type="checkbox"/> FEELING REJECTED    | <input type="checkbox"/> VISUAL DIFFICULTIES  | <input type="checkbox"/> FEARFUL LEAVING HOME |
| <input type="checkbox"/> BEHAVIORAL PROBLEM  | <input type="checkbox"/> STRONG WILLED        | <input type="checkbox"/> "WORRY WART"         |
| <input type="checkbox"/> LEAVING A LOVED ONE | <input type="checkbox"/> TOILET TRAINING      | <input type="checkbox"/> FEW FRIENDS          |
| <input type="checkbox"/> OVERWEIGHT          | <input type="checkbox"/> SMALL FOR AGE        | <input type="checkbox"/> SHY                  |
| <input type="checkbox"/> RAN AWAY FROM HOME  | <input type="checkbox"/> FIGHTING             | <input type="checkbox"/> PICKED ON            |
| <input type="checkbox"/> REPEATED GRADE      | <input type="checkbox"/> READING PROBLEM      | <input type="checkbox"/> TROUBLE WITH POLICE  |

**MARITAL/COMMITTED RELATIONSHIP HISTORY:**

PLEASE LIST ALL MARITAL OR COMMITTED PARTNERS:

DATES OF MARRIAGES	DATES OF DIVORCE/SEPARATIONS	CHILDREN FROM THIS RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

IN YOUR PRESENT RELATIONSHIP DO YOU

ENJOY GOOD COMMUNICATION WITH EACH OTHER?      \_\_\_ YES      \_\_\_ NO

FEEL SATISFIED WITH YOUR SEXUAL RELATIONS?      \_\_\_ YES      \_\_\_ NO

SPEND PRIVATE COUPLE TIME WITH EACH OTHER?      \_\_\_ YES      \_\_\_ NO

SHARE SIMILAR INTERESTS AND VALUES?      \_\_\_ YES      \_\_\_ NO

**EDUCATION HISTORY**

HIGH SCHOOL: \_\_\_\_\_ COLLEGE: \_\_\_\_\_

DEGREES: \_\_\_\_\_ CERTIFICATIONS: \_\_\_\_\_

**MILITARY SERVICE HISTORY:**

BRANCH: \_\_\_\_\_ DATES OF SERVICE: \_\_\_\_\_

**PRIOR MENTAL HEALTH HISTORY:**

HAVE YOU HAD PRIOR MENTAL HEALTH TREATMENT?      \_\_\_ YES      \_\_\_ NO

IF YES:

DATE \_\_\_\_\_

WAS THIS PERSON A:

\_\_\_ PSYCHIATRIST      \_\_\_ PSYCHOLOGIST      \_\_\_ CLINICAL SOCIAL WORKER

\_\_\_ CLINICAL COUNSELOR      \_\_\_ MINISTER      \_\_\_ OTHER

HAVE YOU EVER BEEN HOSPITALIZED FOR EMOTIONAL PROBLEMS?      \_\_\_ YES      \_\_\_ NO

NAME OF HOSPITAL \_\_\_\_\_ DATE \_\_\_\_\_

LOCATION \_\_\_\_\_ HOW LONG? \_\_\_\_\_

DOCTOR WHO TREATED YOU \_\_\_\_\_

MEDICATIONS YOU TOOK \_\_\_\_\_

DO YOU STILL TAKE MEDICATIONS FOR YOUR NERVES?      \_\_\_ YES      \_\_\_ NO

**ALCOHOL /DRUG HISTORY:**

DO YOU HAVE A HISTORY OF ALCOHOL /DRUG ABUSE?      \_\_\_ YES      \_\_\_ NO

IF YOU ARE USING ALCOHOL OR DRUGS HAS THIS RESULTED IN:

\_\_\_ MARITAL PROBLEMS      \_\_\_ MEMORY BLACKOUT

\_\_\_ PROBLEMS WITH FAMILY OR FRIENDS      \_\_\_ PREOCCUPATION WITH ALCOHOL/DRUG

\_\_\_ PROBLEMS ON THE JOB      \_\_\_ LOSS OF CONTROL

\_\_\_ LEGAL PROBLEMS      \_\_\_ WITHDRAWAL SYMPTOMS

\_\_\_ PHYSICAL PROBLEMS      \_\_\_ PERIODS OF ABSTINENCE

\_\_\_ FINANCIAL PROBLEMS      \_\_\_ CHARGES OF DUI or DWI

**LEGAL HISTORY:**

HAVE YOU BEEN IN TROUBLE WITH THE LAW? \_\_\_\_\_ YES \_\_\_\_\_ NO

IF YES, PLEASE CHECK THOSE THAT APPLY TO YOU:

- \_\_\_\_\_ TROUBLE WITH THE LAW AS A JUVENILE?
- \_\_\_\_\_ TROUBLE WITH THE LAW AS AN ADULT?
- \_\_\_\_\_ HAVE LEGAL MATTER PENDING?
- \_\_\_\_\_ HAVE YOU EVER BEEN IN JAIL?

**MEDICAL HISTORY:**

DATE OF LAST PHYSICAL EXAMINATION \_\_\_\_\_

FAMILY DOCTOR \_\_\_\_\_

PLEASE DESCRIBE YOUR CHIEF MEDICAL / PHYSICAL COMPLAINTS \_\_\_\_\_

DO YOU HAVE ANY SPECIAL PROBLEMS WITH HEARING, SPEECH, VISION? \_\_\_\_\_

PLEASE EXPLAIN \_\_\_\_\_

ARE YOU ON ANY MEDICATIONS? \_\_\_\_\_ YES \_\_\_\_\_ NO IF YES, PLEASE LIST: \_\_\_\_\_

PLEASE DESCRIBE ANY SIDE EFFECTS: \_\_\_\_\_

DO YOU HAVE ANY ALLERGIES? \_\_\_\_\_ YES \_\_\_\_\_ NO IF YES, PLEASE DESCRIBE: \_\_\_\_\_

LIST ANY SERIOUS ILLNESSES, INJURIES, OR SURGERIES: \_\_\_\_\_

PLEASE PLACE AN X IN THE LEFT HAND COLUMN IF THIS CONDITION EXISTS. IN THE RIGHT COLUMN, WRITE SELF, FATHER, MOTHER, SISTER, BROTHER, AUNT, UNCLE, ETC.

- |                              |       |
|------------------------------|-------|
| _____ ALCOHOLISM             | _____ |
| _____ ALLERGIES              | _____ |
| _____ MENTAL RETARDATION     | _____ |
| _____ OBESITY                | _____ |
| _____ A DEGENERATIVE DISEASE | _____ |
| _____ MENTAL HEALTH PROBLEMS | _____ |
| _____ SUICIDE                | _____ |
| _____ CANCER                 | _____ |
| _____ DIABETES               | _____ |
| _____ EPILEPSY               | _____ |
| _____ HIGH BLOOD PRESSURE    | _____ |
| _____ HEART TROUBLE          | _____ |
| _____ OTHER                  | _____ |

## MEDICAL CONDITIONS AND SYMPTOMS

PAST / NOW / NEVER

PAST / NOW / NEVER

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FOOD CRAVING FOR SWEETS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ANXIETY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FATIGUE
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ANGER OUTBURSTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEADACHES
							MORNING <input type="checkbox"/>
							EVENING <input type="checkbox"/>
							HOW LONG? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEART PALPITATIONS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BACKACHES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HALLUCINATIONS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BINGEING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEARING VOICES
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BARBITUATES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HYPERTENSION
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BROKEN SLEEP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HAND TREMORS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CANCER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HAY FEVER
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CHRONIC PAIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	INSULIN MEDICATION
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CHEST PAIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ITCHY SKIN
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CONSTIPATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DISTRACTIBILITY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DEPRESSION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LAXATIVES USED
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LEG CRAMPS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DEPERSONALIZATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LOSE BOWEL/ GAS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	“GOING CRAZY” SENSATIONS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LOSES TEMPER EASILY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DIFFICULTY GOING TO SLEEP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MOODY OFTEN
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DIFFICULTY STAYING ASLEEP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MEMORY PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DIZZINESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MUSCLE TWITCHING
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DRUG REACTIONS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MUCH SWEATING
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EARLY MORNING AWAKENING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MOIST PALMS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EMOTIONAL UPSETS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NERVOUS BREAKDOWN
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NERVOUSNESS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CAN’T WORK UNDER PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NERVE MEDICINE
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	COLOR BLIND	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NERVES
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EXHAUSTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OVEREATING
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FAINING SPELLS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OVERWORKED
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FAST PULSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PAIN MEDICINE
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEART MEDICINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PALPITATION
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HORMONES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PERFECTIONIST
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	POOR DIGESTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH MEDICINE
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	POOR APPETITE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	WORRIER, FEELS INSECURE
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TREATED FOR MENTAL CONDITION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	REDUCED/ LACKING SEXUAL DESIRE
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OTHER DRUGS OR ALCOHOL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH UPSETS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SHAKING				FROM FOOD _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SMOKING				FROM MEDICINE _____
			PACKS PER DAY _____				FROM LIQUOR _____

**CURRENT SOURCES OF STRESS:**

PLEASE LIST YOUR MOST SIGNIFICANT SOURCE OF STRESS OR WORRY:

1. \_\_\_\_\_
2. \_\_\_\_\_

WHAT IS THE MAIN GOAL YOU WISH TO ATTAIN IN SEEKING SERVICES?

\_\_\_\_\_  
\_\_\_\_\_

ENVISION HOW YOUR LIFE WOULD BE DIFFERENT IF YOU COULD MANAGE SOME OF THESE PROBLEMS BETTER.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ADDITIONAL INFORMATION : PLEASE ADD ANY INFORMATION YOU FEEL WHICH MIGHT BE HELPFUL IN ASSISTING IN YOU TREATMENT:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**YOUR SIGNATURE BELOW INDICATES YOU UNDERSTAND THE QUESTIONS, COULD ASK FOR ASSISTANCE IF NEEDED AND THAT THIS INFORMATION IS TRUE TO THE BEST OF YOUR KNOWLEDGE.**

\_\_\_\_\_  
**CLIENT SIGNATURE**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**RECEIVED BY**

\_\_\_\_\_  
**DATE**