Christopher J. BH. Bauchman, PsyD, LLC

Licensed Psychologist
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Suite 204
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Client Information Date:_____

Name:_____ Preferred Name:_____

Date of Birth:_____/_____/_____ SSN:_____-_____-_____

Address:_____

City: _____ State: _____ Zip:_____

PHONE NUMBERS OK to leave Messages?

HOME:_____ ◯ Yes ◯ No ◯ Primary Contact?

WORK:_____ ◯ Yes ◯ No ◯ Primary Contact?

MOBILE:_____ ◯ Yes ◯ No ◯ Primary Contact?

WOULD YOU LIKE A REMINDER CALL DAY PRIOR TO APPOINTMENT? ◯ Yes ◯ No

EMAIL:_____

EMERGENCY CONTACT: Name:_____Phone: _____Relation:_____

Insurance Information

Primary Insurance Carrier:_____Phone:_____

Claim Address:_____City:_____ Zip:_____

Name of Insured:_____ Relation to Client:_____

Insured ID:_____Group #:_____

Insured DOB:_____/_____/_____ Phone:_____Employer:_____

Insured's address:_____ City:_____ Zip:_____

Secondary Insurance Carrier:_____Phone:_____

Claim Address:_____City:_____ Zip:_____

Name of Insured:_____ Relation to Client:_____

Insured ID:_____Group #:_____

Insured DOB:_____/_____/_____ Phone:_____Employer:_____

Insured's address:_____ City:_____ Zip:_____

I hereby authorize the release of all medical records necessary to process an insurance claim. I hereby authorize my insurance carrier to make payments directly to Christopher J. BH. Bauchman, PsyD, Licensed Psychologist. I understand that I am financially responsible for all charges, regardless of insurance, unless otherwise written by Christopher J. BH. Bauchman, PsyD, Licensed Psychologist.

Signature:_____ Name:_____ Date:_____

Background Information Today's Date:_____/_____/_____

Name:_____ Referred By:_____

Gender: _____ Sexual Orientation: _____

Racial and/or ethnic group identification: _____

Please describe what brought you here today:

Have you sought treatment for this problem before? ◯ Yes ◯ No

How is your sleep? (how many hours/night, waking, difficulty)

Have you gained or lost weight without trying in the last six months? ◯ Yes ◯ No

Are you struggling with any the following?

◯ Aggression
◯ Alcohol or drug use
◯ Anxiety/worry
◯ Body image concern
◯ Change in appetite
◯ Compulsive behavior
◯ Crying spells
◯ Distractibility
◯ Eating problems
◯ Fatigue
◯ Gambling problems
◯ Guilt/shame
◯ Hallucinations
◯ Hearing voices
◯ Hopelessness
◯ Hyperactivity
◯ Impulsivity
◯ Irritability
◯ Loneliness
◯ Loss of pleasure
◯ Low self-worth
◯ Memory difficulties
◯ Nightmares
◯ Obsessive thoughts
◯ Overuse of internet
◯ Panic attacks
◯ Parenting problems
◯ Racing thoughts
◯ Relationship problems
◯ Sadness
◯ Self-harm
◯ Sexual problems
◯ Sleep problems
◯ Stress
◯ Suspicion/paranoia
◯ Thoughts of death
◯ Thoughts of harming
◯ Wide mood swings
◯ Work/school problems

Are any of the following impacted by what brings you in?

◯ Exercise
◯ Finances
◯ General health
◯ Handling everyday tasks
◯ Housing
◯ Relationships
◯ Hygiene
◯ Legal matters
◯ Sexual functioning
◯ Recreational activities
◯ Self-esteem
◯ Sexual activity
◯ Spirituality/faith

Have you ever had thoughts, made statements, or attempted to hurt yourself? ◯ Yes ◯ No

Have you ever had thoughts, made statements, or attempted to hurt someone else? ◯ Yes ◯ No

Have you ever had any of the following experiences?

◯ Crime victim	◯ Live in a foster home	◯ Physical abuse
◯ Emotional abuse	◯ Loss of loved one	◯ Placed a child for adoption
◯ Homelessness	◯ Multiple family moves	◯ Serious auto accident
◯ Life threatening illness	◯ Neglect	◯ Sexual abuse or assault
◯ Adoption	◯ Parental substance abuse	◯ Violence in the home

Personal History

Family of Origin: Please list the members of your family of origin (parents, brothers, sisters, etc.)

Name	Relationship	Age	Occupation/School	Quality of Relationship

Friends/ Chosen Family: Please list the members of your chosen family or community who are important in your daily life

Name	Relationship	Age	Occupation/School	Quality of Relationship

Whom did you live with mostly when you were a child? (Under age 16)

◯ Biological Parents

◯ Father Only

◯ Mother Only

◯ Foster Care

◯ Other Relative

◯ Parent & Stepparent

◯ Adoptive Parents/Family

◯ Other_____

During your childhood were you ever injured from the discipline used by your parents? ◯ Yes ◯No

During your childhood did you ever see your care takers have physical fights with each other? ◯ Yes ◯No

Were you ever arrested by the police before you turned age 16? ◯ Yes ◯No

You are currently: ◯ Single ◯ Dating ◯ Separated ◯ Engaged ◯ Partnered
◯ Domestic Partnership ◯ Married ◯ Divorced ◯ Widowed

How long?_____

Do you feel safe in your current relationship? ◯ Yes ◯No

How satisfied are you with your marriage/relationship? (circle #)

Extremely Dissatisfied 1 2 3 4 5 6 7 Extremely Satisfied

How satisfied are you with your relationship with your spouse/partner? (circle #)

Extremely Dissatisfied 1 2 3 4 5 6 7 Extremely Satisfied

How satisfied are you with your partner as a spouse/significant other? (circle #)

Extremely Dissatisfied 1 2 3 4 5 6 7 Extremely Satisfied

How satisfied are you with your sex life in your current relationship? (circle #)

Extremely Dissatisfied 1 2 3 4 5 6 7 Extremely Satisfied

Previous Relationships/Marriages:_____

Is there a partner from a previous relationship that is making your feel unsafe now? ◯ Yes ◯No

Do you have any children under the age of 18 living with you in your home? ◯ Yes ◯ No

Child #1 - Age:____ Sex: _____ Gender: _____

Child #2 - Age:____ Sex: _____ Gender: _____

Child #3 - Age:____ Sex: _____ Gender: _____

<u>Military Service</u>:

Highest level of education:_____

Employed?◯ Yes ◯No Position & how long?_____

Religious or spiritual practice or affiliation?_____

Please describe your support system:_____

Hobbies?

Have you ever been sued?◯ Yes ◯No Have you ever initiated a lawsuit?◯ Yes ◯No
(If yes, please explain)

Medical Information

Primary Healthcare Provider:_____ Clinic:_____

PHP Address:_____

PHP Phone:_____

Last Physical:_____

Current health concerns or illnesses:_____

Past illnesses:_____

Surgeries:

Have you ever had a head injury or concussion from a fall, crash, or other kind of accident?_____

Are you currently taking non-psychiatric medications?◯ Yes ◯No (If yes, please list):

Mental Health History

Have you ever participated in therapy or counseling before? ◯ Yes ◯ No

Dates Provider What was Helpful/Unhelpful?

Are you currently prescribed any psychiatric medication? ◯ Yes ◯ No If yes, are you taking them as prescribed?

Have you previously been prescribed medication for your nerves, depression, anxiety, sleep, etc.? ◯ Yes ◯ No (If yes, please list)

Have you ever been hospitalized or received inpatient treatment for a mental health condition?
◯ Yes ◯ No (If yes, please list when, where, why)

Are there members of your family who have been on medication, hospitalized or in some other way treated for a mental health issue? ◯ Yes ◯ No (If yes, please explain)

Substance Abuse

Please describe your caffeine intake:_____

Please describe your alcohol use:_____

Alcohol use in the past:_____

Please describe any current or past drug use including, cocaine, crack, ecstasy, heroin, inhalants, marijuana, methamphetamines, pain killers, PCP/LSD, Steroids, tobacco, tranquilizers or other:

Are there members of your family who have had problems with alcohol or drugs? ◯ Yes ◯ No
(If yes, please explain)

Legal History

Are you currently or have you been in the past involved in any legal proceedings? ◯ Yes ◯ No

If yes, please describe:_____

Have you ever been arrested? ◯ Yes ◯ No

If yes, please describe:_____

Expectations

What do you hope to get out of counseling, what would you like to see change?

I expect counseling to last

◯ 0-6 sessions ◯ 6-10 sessions ◯ 11-20 sessions ◯ 21-52 sessions ◯ Over 52 sessions

After counseling, I expect the issues I intend to address to be:

◯ No better ◯ Slightly better ◯ Moderately better ◯ Mostly better ◯ Completely better

The pain and distress caused by what is bringing me in is:

◯ Very mild ◯ Mild ◯ Moderate ◯ Severe ◯ Very Severe

The pain and distress caused <u>for others</u> by what is bringing me in is:

◯ Very mild ◯ Mild ◯ Moderate ◯ Severe ◯ Very Severe

Thank you for providing me with this important information.

BRIEF PATIENT HEALTH QUESTIONNAIRE (Brief PHQ)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip a question.

Name_____ **Age**_____ **Sex:** ☐ **Female** ☐ **Male** **Today's Date**_____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

		Not at all	Several days	More than half the days	Nearly every day
a.	Little interest or pleasure in doing things	☐	☐	☐	☐
b.	Feeling down, depressed, or hopeless	☐	☐	☐	☐
c.	Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
d.	Feeling tired or having little energy	☐	☐	☐	☐
e.	Poor appetite or overeating	☐	☐	☐	☐
f.	Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
g.	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h.	Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
i.	Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

2. Questions about anxiety.

		NO	YES
a.	In the last 4 weeks, have you had an anxiety attack—suddenly feeling fear or panic?	☐	☐
	If you checked "NO," go to question 3.		
b.	Has this ever happened before?	☐	☐
c.	Do some of these attacks come suddenly out of the blue—that is, in situations where you don't expect to be nervous or uncomfortable?	☐	☐
d.	Do these attacks bother you a lot or are you worried about having another attack?	☐	☐
e.	During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, your heart racing or pounding, dizziness or faintness, tingling or numbness, or nausea or upset stomach?	☐	☐

3. If you checked off any problems on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ **Not difficult at all** ☐ **Somewhat difficult** ☐ **Very difficult** ☐ **Extremely difficult**

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FOR OFFICE CODING: Maj Dep Syn if answer to #1a or b and five or more of # 1a–i are at least "More than half the days" (count #1i if present at all). Other Dep Syn if #1a or b and two, three, or four of #1a–i are at least "More than half the days" (count #1i if present at all). Pan Syn if all of #2a–e are "YES."

4. In the last 4 weeks, how much have you been bothered by any of the following problems?

		Not bothered	Bothered a little	Bothered a lot
a.	Worrying about your health	☐	☐	☐
b.	Your weight or how you look	☐	☐	☐
c.	Little or no sexual desire or pleasure during sex	☐	☐	☐
d.	Difficulties with husband/wife, partner/lover, or boyfriend/girlfriend	☐	☐	☐
e.	The stress of taking care of children, parents, or other family members	☐	☐	☐
f.	Stress at work outside of the home or at school	☐	☐	☐
g.	Financial problems or worries	☐	☐	☐
h.	Having no one to turn to when you have a problem	☐	☐	☐
i.	Something bad that happened recently	☐	☐	☐
j.	Thinking or dreaming about something terrible that happened to you in the past—like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act	☐	☐	☐

		NO	YES
5.	**In the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act?**	☐	☐

6. What is the most stressful thing in your life right now? _____

		NO	YES
7.	**Are you taking any medication for anxiety, depression, or stress?**	☐	☐

8. FOR WOMEN ONLY: Questions about menstruation, pregnancy, and childbirth.

a. Which best describes your menstrual periods?

☐ **Periods are unchanged** ☐ **No periods because pregnant or recently gave birth** ☐ **Periods have become irregular or changed in frequency, duration, or amount** ☐ **No periods for at least a year** ☐ **Having periods because taking hormone replacement (estrogen) therapy or oral contraceptives**

		NO (or does not apply)	YES
b.	During the week before your period starts, do you have a serious problem with your mood—like depression, anxiety, irritability, anger, or mood swings?	☐	☐
c.	If YES, do these problems go away by the end of your period?	☐	☐
d.	Have you given birth within the last 6 months?	☐	☐
e.	Have you had a miscarriage within the last 6 months?	☐	☐
f.	Are you having difficulty getting pregnant?	☐	☐

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