Candy Katoa, Psy.D.
Clinical Psychologist
CA PSY 24477

ADULT BACKGROUND INFORMATION

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____

_____

Primary Phone: _____ (cell/work/home/other) OK to leave message? Y/N

Secondary Phone: _____ (cell/work/home/other) OK to leave message? Y/N

Email: _____ OK to email you? Y/N

Emergency Contact Name: _____

Relationship to Emergency Contact: _____

Emergency Contact Phone: _____

Current Physician's Name: _____

Physician's Phone: _____

List Any Allergies: _____

Relationship Status (circle one): Single In a Relationship Married Separated Divorced Widowed

Do you live with anyone? Y/N If yes, who? _____

Are you currently working? Y/N Employer: _____

Occupation/Job Position: _____

Race/Ethnicity: _____ Sexual Orientation: _____

Religion (if applicable): _____

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What brings you to therapy? How long have these problems been bothering you? List top 3 concerns.

1) _____

2) _____

3) _____

Below is a list of common challenges people face. Please check any that apply to you at this time.

Anxiety
___ Worries/General Anxiety ___ Specific fears/Phobias ___ Panic attacks
___ Obsessive thinking ___ Compulsive behaviors ___ Social Anxiety

Mood
___ Sadness or Depression ___ Anger or Irritability ___ Loss of pleasure in life
___ Frequent crying ___ Loss of energy ___ Thoughts of suicide
___ Mood swings ___ Mania ___ Feeling too excited or hyper

Behaviors
___ Cutting or self injury ___ Problems with eating ___ Purging foods ___ Hoarding
___ Skin picking ___ Hair pulling ___ Nail biting ___ Tics

Sleep
___ Problems falling or staying asleep ___ Fatigue/tiredness during the day
___ Nightmares ___ Sleeping too much

Cognitive
___ Problems with attention or concentration ___ Racing thoughts ___ Memory problems
___ Thoughts that don't make sense ___ Paranoia ___ Problems with decision making

Interpersonal
___ Problems making or keeping relationships ___ Relationship/Marriage problems
___ Recent Breakup/Separation/Divorce ___ Difficulties with assertiveness
___ Problems with sex or intimacy ___ Family problems

Other
___ History of abuse (emotional, physical, sexual) ___ Traumatic experience ___ Grief or loss
___ Problems with alcohol or drugs ___ Medical problems ___ Spirituality/Religious concerns
___ Problems with job/school ___ Financial problems ___ Legal problems
___ Body image concerns ___ Learning problems
___ Other: _____

Do you have any health problems or chronic conditions? Y / N If so, please list them below.

_____

_____

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Have you ever had a head injury? Y/N If yes, please explain: _____

Have you ever been hospitalized? Y/N If yes, please state reason for admission and date.

_____

Current Height: _____ Current Weight: _____

Current Medications (including over the counter medications and supplements)

Medication	Dosage	Purpose

Current & Previous Mental Health Providers

Provider Name	Dates of Treatment	Reason for Treatment

Developmental History

Where were you born? _____ Where did you grow up? _____

Who did you live with growing up? _____

What is the highest grade you completed in school? _____

Where did you graduate from? _____

Have you ever been in trouble with the law? _____

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Family History

Do you have any family history with the following?

Anxiety	Y	N	Don't Know	Who: _____
Depression	Y	N	Don't Know	Who: _____
Bipolar Disorder/Mania	Y	N	Don't Know	Who: _____
Substance Use	Y	N	Don't Know	Who: _____
Eating Disorder	Y	N	Don't Know	Who: _____
Schizophrenia/Psychosis	Y	N	Don't Know	Who: _____
Attention Problems/ADD/ADHD	Y	N	Don't Know	Who: _____
Learning/Developmental Disability	Y	N	Don't Know	Who: _____

Substance Use History

Have you ever used any of the following substances?

Alcohol	Never	Past	Currently	How much: _____
Tobacco	Never	Past	Currently	How much: _____
Marijuana	Never	Past	Currently	How much: _____
Stimulants	Never	Past	Currently	How much: _____
Cocaine/Crystal Meth	Never	Past	Currently	How much: _____
Ecstasy/MDMA	Never	Past	Currently	How much: _____
Opioids	Never	Past	Currently	How much: _____
Sedative/Hypnotics that are not prescribed to you	Never	Past	Currently	How much: _____

Thank you for taking the time to fill this form out!