Freedom First Psychological Services, PLLC
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Name: _____ **Date of Birth:** _____

Marital Status: _____ **Age:** _____ **Gender:** _____

How did you get here today? ☐ Drove self ☐ Driven by: _____
☐ Walked ☐ Public Transportation (specify): _____

How many miles did you travel to get here today? _____ miles

What is your highest level of education? ☐ Less than high school ☐ Some high school ☐ High school graduate
☐ Obtained GED ☐ Some college (how many years) _____
☐ Vocational training program (type of program) _____
☐ College degree (type of degree) _____
☐ Post-graduate school (type of degree) _____
☐ Other (please specify) _____

Type of education placement: ☐ Regular ☐ Special Education for _____
☐ Standard diploma ☐ Special education diploma

What is your current employment status? ☐ Not employed
☐ employed part-time as a _____ since _____
☐ employed full-time as a _____ since _____

If you are currently not working, what was your last job title? _____
When were you last employed? _____ How long did you work there? _____
Reason for leaving? _____

If you have been unable to work, please state reasons: _____
_____
_____
_____
_____
_____

Have you ever been hospitalized for PSYCHIATRIC (emotional) reasons? ☐ Yes ☐ No

Dates	Name/Location of Hospital	Reason for Hospitalization	Diagnosis

If you are or have been in treatment with a counselor, psychiatrist, or psychologist, please provide the following:

Dates	Frequency of Treatment	Where?	With Whom?

Have you had any significant symptoms of depression, anxiety, or other emotional concerns during the past few months? ☐ Yes ☐ No

If yes, please describe: _____

If you are currently under psychiatric care, has your emotional condition improved?

☐ Yes, my symptoms are controlled by treatment
☐ Improved, but occasionally experience symptoms
☐ No, symptoms are worse
☐ Improved, but still experience symptoms
☐ No, symptoms are the same

Please describe your sleeping habits.

☐ No sleep concerns
☐ Nightmares/Distressing Dreams
☐ Difficulty falling asleep (how long to fall asleep) _____
☐ Wake up usually ___ times nightly

Average number of hours of sleep: _____ hours

How is your appetite?

☐ No appetite concerns
☐ Loss of Appetite
☐ Weight loss of ____ lbs.
☐ Increased appetite
☐ Weight gain of ____ lbs.

Do you currently drink alcohol? ☐ Yes ☐ No If yes, how often? _____ How much? _____

If yes, check all that apply? ☐ Beer ☐ Wine ☐ Liquor

If you no longer drink, when did you stop? _____

Do you have a history of alcohl abuse? ☐ Yes ☐ No

Do you currently use drugs? ☐ Yes ☐ No If yes, how often? _____ How much? _____

If yes, check all that apply? ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Other: _____

If you no longer use drugs, when did you stop? _____

If you have been or currently in an alcohol or drug treatment program, please complete:

Dates	Facility Name	Type of Treatment	Results of Treatment

Have you ever been arrested? ☐ Yes ☐ No
If yes, date: _____ Charges: _____
Sentence: _____
Current Legal Status: _____

Have you ever served in the military? ☐ Yes ☐ No
If yes, dates: _____ Branch: _____ Discharge Type: _____

Is there a family history of:
Psychiatric illnesses: ☐ Yes ☐ No If yes, please explain: _____
Alcohol and/or drugs: ☐ Yes ☐ No If yes, please explain: _____
Cognitive problems: ☐ Yes ☐ No If yes, please explain: _____

Do you live alone? ☐ Yes ☐ No If not, with whom do you live? _____
Do you have a driver's license? ☐ Yes ☐ No
Do you have a vehicle? ☐ Yes ☐ No

Which of these can you do?	How many times a week?	If you don't, why not?
☐ Cooking		
☐ Cleaning		
☐ Laundry		
☐ Shopping		
☐ Childcare		
☐ Shower by yourself		
☐ Bathe by yourself		
☐ Dress yourself		

Check off the activities you do:
☐ Watch television ☐ Listen to the radio ☐ Read
☐ Play sports/exercise ☐ Socialize with friends ☐ Go out to: _____
☐ Use the internet ☐ Have a hobby: _____

Medical History

List your current medical problems:

_____
_____
_____
_____
_____
_____
_____

List all operations and hospital admissions:

Year	Name/Location of Hospital	What was the reason?

Has your doctor ever told you that you have or had:	Yes	No	Year it began?
High blood pressure			
Diabetes			
Heart attack			
Other heart disease			
Asthma			
Emphysema			
Seizures			

List all of the medications you are now taking:

Name of Medication	Dose	How often	Reason taking medication

Name of Primary Care Physician: _____
Physician's Phone Number: _____
Physician's Office Location: _____
Last time had appointment with primary care physician: _____

Have you ever used?	Check one or more:	When did you start?	Do you still use?	If yes, how much do you use?	If not, when did you stop?	What was the most you ever used?
Tobacco	☐ Cigarettes ☐ E-cigarettes					
	☐ Pipe ☐ Vapor					
	☐ Cigars ☐ Chewing Tobacco					
Alcohol	☐ Beer ☐ Wine ☐ Liquor					
Street Drugs	☐ Marijuana					
	☐ Cocaine ☐ Heroin					
	☐ Other: _____					