Dr. Sumer Ledet
PSYCHOLOGICAL SERVICES

PERSONAL INFORMATION

Date: _____

Name: (sex) (age) (DOB)
Address:
Phone #: (Cell) May I leave you a message?
Phone #: (Home) May I leave you a message?
Phone #: (Work) May I leave you a message?
Email address: May I email you?

How did you hear about my services? _____

Legal guardian (if applicable): _____

Guarantor Information (person responsible for payment, if different from above):

Guarantor Name:	
Guarantor Address:	
Guarantor Cell phone number:	
Guarantor Work phone number:	
Guarantor Work Address:	

What is the primary reason you scheduled this appointment?

_____

_____

Health History:

Do you currently have any health problems? Yes _____ No _____

Current physician:

_____

Telephone number of physician:

_____

Medical Problem	Medications	Dosage

Have you, in the past, been hospitalized or had a major medical problem? Yes _____ No _____
Please describe:

_____

_____

	YES	NO
Have you ever had a head injury?		
Have you ever had seizures or convulsions?		
Have you ever lost consciousness for any reason?		

If you answered yes to any of the above, please describe:

_____

_____

	Poor	Satisfactory	Good	Great
How do you sleep at night?				
Describe sleep problems (if applicable):				

	YES	NO
Do you exercise?		
How often?		

Please list any difficulties you experience with your appetite or eating patterns (if applicable):
Please describe your diet:

	YES	NO
Do you drink alcohol more than once per week?		
If yes how often?		
Have you ever felt the need to cut down on your drinking?		
Have you ever felt annoyed by criticism of your drinking?		
Have you ever felt guilty about your drinking?		
Have you ever taken a morning “eye opener”?		
How much beer, wine, or liquor do you consume weekly on average?		
Are there times where you run out of money as a result of drinking?		
Are there times where you drink to unconsciousness?		

	Daily	Weekly	Monthly	Infrequently	Never
How often do you engage in recreational drug use?					
What drugs (if any) have you used in the past ten years, including forms of “legal” marijuana and over-the-counter products such as glue or gasoline?					

	YES	NO
Have you ever been arrested or incarcerated?		
If yes, list dates and charges:		
Are you required by a court, the police, or a probation/parole officer to have this appointment?		

Please list current and pending charges here (if any):
Current Attorney's name (if applicable):
Pending court dates (if applicable):

	Please respond below:
How many cups of regular coffee do you drink each day?	
How many cups of tea do you drink each day?	
How many sodas do you drink each day?	
How many energy drinks do you drink each day?	
Do you take caffeine pills daily?	
How much tobacco do you smoke or chew each day?	

	YES	NO
Are you feeling afraid of anything or anyone in particular?		
If yes, please describe:		

	YES	NO
Do you consider yourself to be religious or spiritual?		
Any spiritual concerns?		
Current religious denomination/affiliation:		

	None	Some/Irregular	Active
Involvement:			

How important is spirituality/religion in your life?
Ethnicity/national origin:
And/or other way you identify yourself and consider important:

	YES	NO
Are you currently in a romantic relationship?		
If yes, for how long:		
If yes, on a scale of 0-10 (10 being the best ever), how would you rate the relationship?		

Current Living Situation: (please check one)

Single		Married		Living Together	
Separated		Divorced		Widowed	

Members of current household:

Name	Sex	Age	Relationship	Employer/School Grade

Ex-Spouses, Children, Significant friends outside of home:

Name	Sex	Age	Relationship	Location

Other social supports (include church, social clubs, etc.)

_____

_____

Employment:

Are you currently employed: (please check one)

Full time		Part time		unemployed	
Other		If other, describe:			

Name of employer: _____ Years with company: _____

Title and Duties: _____

Do you like this sort of work? Yes _____ No _____

Education:

Did you experience any learning disabilities? Yes _____ No _____

Did you fail any grades, including in college/trade school? Yes _____ No _____

Is so, what grades and subjects? _____

Were you often in trouble in school? _____

What was the highest grade you completed? _____

Are you currently attending school? Yes _____ No _____

Where? _____

Please indicate how often you have each concern.

Problems:	Never	Occasionally	Often	Very Often
Physical Appearance				
Health problems or concerns				
Physical pain or discomfort				
Shortness of breath				
Racing Heartbeat				
Headaches				
Dizziness, Lightheadedness, or fainting				
Confusion or Disorientation				
Anxious or nervous				
Restless, on edge				
Poor attention or concentration				
Racing thoughts				
Spending too much time organizing or planning				
Difficulty making decisions or completing tasks				
Trouble getting a thought out of your head				
Behaviors you have to repeat for no reason				

Trouble throwing things away				
Mood swings, rapid changes in your feelings				
Depression, sadness or feeling down				
Memory problems				
Easily fatigued				
Increased or decreased appetite				
Sleep problems				
Loss of interest in pleasurable activities				
Irritable				
Flat or reduced emotions				
Negative thoughts, attitudes or feelings				
Unresponsive to praise or criticism				
Loneliness				
Feelings of helplessness				
Feeling inferior				
Being easily influenced by others				
Trouble being alone				
Feeling distant or detached from others				
Feeling different from others				
Difficulty trusting others				
Trouble having close friends				
Feeling no one likes you				
Thoughts of harming yourself				
Trouble controlling your temper or anger				
Conflict with authority figures				
Lying or stealing				
Fire setting or other property destruction				
Unwanted impulses, urges or desires				
Intrusive or unwanted thoughts or images				
People wanting to harm you				
Thoughts of harming someone else				
Hearing voices that others do not hear				
Seeing things others do not see				
Repeated images or experiences of a traumatic event				
Feeling out of touch or separate from your body				
Confusion about who you are				
Feeling you have more than one personality				
Eating, food, exercise, or weight concerns				
Drug or alcohol problems				

Gambling				
Work, job, school or career problems				
Financial problems				
Legal problems				
Marriage, family or relationship problems				
Sex related problems				
Religious or spiritual problems				

How long have these problems been occurring?

_____

Do these problems change in are regular pattern or way? Yes _____ No _____

If yes, is it based on:

Time of day, week, month or year		Particular situations / events	
Particular locations		Particular people you meet	
Other Factors:			

Previous Counseling / Psychotherapy:

Have you ever been involved in counseling/psychotherapy? Yes _____ No _____

Please provide the following information:

Therapist	Dates	Reason for ending sessions

Do you see a psychiatrist? Yes _____ No _____

If yes, list psychiatrist name here:

_____

Telephone number of psychiatrist:

_____

Diagnosis	Medications	Dosage

List any vitamins, supplements or over the counter medications here:

_____

_____

	YES	NO

Have you ever had a drug or alcohol problem?		
Have you ever tried to harm or kill yourself?		
Have you ever tried to kill someone else?		
Have you ever been hospitalized for mental health treatment?		

If you answered yes to any of the above, please describe and include dates:

_____
_____
_____
_____
_____

Childhood and Relatives:

Were you primarily raised by :

Both birth parents		mother		father	
Foster/adoptive parents		Other (describe):			

Are the adults who raised you still alive?

Mother _____ Father _____ Other (name) _____

	Excellent	Good	Okay	Poor
Childhood relationship with Mother:				
Present relationship with Mother:				

	Excellent	Good	Okay	Poor
Childhood relationship with Father:				
Present relationship with Father:				

Other significant people from your childhood? Describe relationships.

_____
_____
_____
_____

Please provide the following information on your brothers and sisters:

Relationship codes: FB = full brother HB = half-brother SB = step brother AB = adopted brother
FS = full sister HS = half-sister SS = step sister AS = adopted sister

Name	Age	Relationship	Quality of Childhood Relationship	Quality of Current Relationship

During your childhood, were you:

Very happy		Happy		Fairly happy	
Unhappy		Very unhappy			

	YES	NO
Do you make friends easily?		
Do you have many friends?		
Were you ever physically, emotionally, or sexually abused as a child?		
Were you ever physically, emotionally, or sexually abused as an adult?		
Have any family members had drug or alcohol abuse problems?		
If yes, please describe:		
Have any family members had problems with sadness, depression, excessive energy, or mood swings?		
If yes, please describe:		
Have any family members seemed unusual, peculiar, or been hospitalized for psychiatric problems?		
If yes, please describe:		
Have any family members tried to harm or kill themselves?		

ANYTHING ELSE YOU WOULD LIKE ME TO KNOW:

_____

_____

_____

_____

_____

_____

Signature Date