Oben Health Services LLC

Elsa Oben, Psy.D.
Licensed Psychologist

710 Oakfield Drive, Suite 153
Brandon, Fl 33511

P: 813.654.0503
F: 813.653.3963

Today's date: _____ **Client Information - Adult form**

Note: If you have been a patient here before, please fill in only the information that has changed.

A. Identification
Your name: _____ Date of birth: _____ Age: ____
Nicknames or aliases: _____ Social Security #: _____
Home street address: _____ Apt.: _____
City: _____ State: _____ Zip: _____
Home/evening phone: _____ e-mail: _____
Calls or e-mail will be discreet, but please indicate any restrictions: _____

B. Referral: Who gave you my name to call?
Name/Organization: _____

C. Religious and racial/ethnic identification
Current religious denomination/affiliation ❑ Protestant ❑ Catholic ❑ Jewish ❑ Islamic ❑ Buddhist ❑ Hindu
Other (specify): _____
Involvement: ❑ None ❑ Some/irregular ❑ Active
How important are spiritual concerns in your life? _____
Which (if any) church, synagogue, temple, or meeting are you involved with? _____
Ethnicity/national origin: _____ Race: _____ or other similar way you identify yourself and consider important: _____

D. Your medical care: From whom or where do you get your medical care?
Clinic/doctor's name: _____ Phone: _____
Address: _____

E. Insurance information
Policy holder's name (if different from patient): _____
Policy holder's date of birth: _____ Policy holder's ID/SS #: _____
Policy holder's employer: _____
Name of Insurance: _____ Insurance customer service phone #: _____
Policy #: _____ Group #: _____

F. Emergency information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: _____ Phone: _____ Relationship: _____

Address: _____

Significant other/nearest friend or relative not residing with you: _____

G. Your education and training

Dates From	Dates To	Schools	Special classes?	Adjustment to school	Did you graduate?

H. Employment and military experiences

Dates From	Dates To	Name of employers	Job title or duties	Reason for leaving

I. Family-of-origin history

Relative	Name	Current age (or age at death)	Illnesses (or cause of death, if deceased)	Education	Occupation
Father					
Mother					
Brothers					
Sisters					
Stepparents					
Grandparents					
Uncles/aunts					

J. Marital/relationship history

	Spouse's name	Spouse's age	Your age	Your age when	Has spouse remarried?
First					
Second					
Third					

K. Significant nonmarital relationships

	Name of other person	Person's age	Your age	Your age	Reasons for ending
First					
Second					
Third					
Current					

L. Children Indicate those from a previous marriage or relationship with "P" in the last column.

Name	Current age	Sex	School	Grade	Adjustment problems?	P?

Client Information (cont.)

Note: **If you were a patient here before, please fill in only the information that has changed.**

A. Identification

Name: _____ Date: _____

B. Chief concern

Please describe the main difficulty that has brought you to see me: _____

_____

_____

_____

C. Treatment

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

❑ No ❑ Yes If yes, please indicate:

When? From whom? For what? With what results?

2. Have you ever taken medications for psychiatric or emotional problems? ❑ No ❑ Yes If yes,please indicate:

When? From whom? Which medications? For what? With what results?

D. Relationships in your family of origin.
Please describe the following:

1. Your parents' relationship with each other: _____
_____
_____
_____

2. Your relationship with each parent and with any other adults present: _____
_____
_____
_____

3. Your parents' medical problems, drug or alcohol use, and mental or emotional difficulties: _____
_____
_____
_____

4. Your relationship with your brothers and sisters, in the past and present: _____
_____
_____
_____

E. Health
List all illnesses, hospitalizations, medications, allergies, head injuries, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition	Age	Treated by whom?	Consequences?

F. Present relationships

1. How do you get along with your present spouse or partner? _____
_____
_____
_____

2. How do you get along with your children? _____
_____
_____
_____

G. Chemical use

1. How many cups of regular coffee do you drink each day? _____ How many cups of tea? ____. How many sodas/pop with caffeine (Coke, Pepsi, Mountain Dew, Dr. Pepper, Orange Crush, etc.)? ____ How many "energy drinks"? ____ How often do you use No Doz or similar caffeine pills? _____ .

2. How much tobacco do you smoke or chew each week? _____

3. Have you ever felt the need to cut down on your drinking? ❑ No ❑ Yes

4. Have you ever felt annoyed by criticism of your drinking? ❑ No ❑ Yes

5. Have you ever felt guilty about your drinking? ❑ No ❑ Yes

6. Have you ever taken a morning "eye-opener"? ❑ No ❑ Yes

7. How much beer, wine, or hard liquor do you consume each week, on the average?
_____

8. Are there times when you drink to unconsciousness, or run out of money as a result of drinking? ❑ No ❑ Yes

9. Have you ever used inhalants ("huffing"), such as glue, gasoline, or paint thinner? ❑ No ❑ Yes If yes, which and when?
_____

Which drugs (not medications prescribed for you) have you used in the last 10 years? _____
_____
_____

Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects, and so forth:
_____
_____
_____