KATHLINE COLVIN, Ph.D. **Pacifica Psychological Services**

3419 Via Lido, Suite 173 – Newport Beach. CA 92663 - (714) 593-6900

CONFIDENTIAL BACKGROUND INFORMATION

Name:_____ Today's Date: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Position: _____

Address: _____

Business Telephone: _____ How Long: _____

Birthdate: _____Highest Level of Education:_____

Social Security #: _____ Driver's License #: _____

Religion: _____ Ethnic Background: _____

Referred by: _____

Consent to Acknowledge Referral (Date if consent is granted): _____

Signature (if consent is granted): _____

Person to call IN CASE OF EMERGENCY: _____

Business Telephone: _____ Home Telephone: _____

Cell Phone: _____ Relationship: _____

Nearest Relative Not Residing With You: _____

Telephone: _____ Relationship: _____

RELATIONSHIP HISTORY:

Marital Status: _____ No. of Years: _____

Spouse/Partner's Name: _____

Birthdate: _____ Age: _____

Spouse/Partner's Employer: _____

Spouse/Partner's Employer's Address: _____

Spouse/Partner's Employer's Phone:_____

Spouse/Partner's Social Security #: _____ Spouse/Partner Driver's Lic #: _____

Children (Names and Ages):_____

Step-Children (Name and Ages): _____

Grandchildren (Names and Ages): _____

Parents (Names, Ages or year of death): _____

Step-Parents (Names, Ages or year of death): _____

Siblings (Names and Ages): _____

MEDICAL HISTORY:

Major Illnesses: _____

Chronic Illnesses: _____

Hospitalizations: _____

Accidents: _____

Current Medications: _____

Personal Physician: _____

Physician's Specialty: _____

Physician's Address: _____

Physician's Phone Number: _____

Date of Last Office Visit: _____

Drug and Alcohol Use (Current): _____

Past Drug and Alcohol Use: _____

Addictions: _____

Recovery/Treatment Programs: _____

Eating History: _____

History of Eating Disorders: _____

Treatment Programs: _____

Height: _____Weight: _____ Highest Weight: _____ Lowest Weight: _____

FAMILY HISTORY:

Family Medical History: _____

Family Diagnoses: _____

Treatment: _____

Family History of Alcoholism: _____

Family History of Drug Abuse: _____

Family History of Psychological Problems: _____

Family Suicidal Behaviors: _____

Family History of Violent Behaviors: _____

Other History: _____

PATIENT HISTORY OF PSYCHOTHERAPY AND PSYCHIATRIC TREATMENT:

Present Problem/Symptoms: _____

_____

Current Diagnoses:_____

Treatment (Type): _____

Physician/Psychotherapist's Name(s): _____

Inclusive Dates of Treatment: _____

Physician's Phone Number: _____

Psychotherapist's Phone Number: _____

Past Problems/Symptoms: _____

Past Diagnoses: _____

Treatment (Type): _____

Physician/Psychotherapist's Name(s): _____

Inclusive Dates of Treatment: _____

Physician's Phone Number: _____

Psychotherapist's Phone Number: _____

SOCIAL, OCCUPATIONAL & FAMILY CONCERNS:

Describe your Social Network: _____

_____

Describe your Friendships (Close Friends, Friends at Work, etc.): _____

_____

How often do you socialize with you friends? _____

_____

Are you currently in a romantic relationship? _____

Please describe your relationship, and comment on your satisfaction or dissatisfaction in your relationship:_____

_____

Do you talk to others about your personal concerns, and the issues that bring you into therapy?

_____

_____

Describe your current living situation? Do you live alone, or with others? _____

_____

How do you feel about your work? Describe your satisfactions and dissatisfactions with work:

_____

_____

Describe hobbies and recreational activities that you enjoy: _____

_____

CURRENT ISSUES:

Please describe the major concerns that you would like to address in therapy:_____

_____

_____

_____