Confidential Personal History
Rochester Psychological Associates

Your answers to the questions below will assist me in providing you with appropriate psychological services. The information you provide cannot be shared with anyone without your written permission.
Please complete ALL the questions as accurately as you can. If a question does not apply to you, indicate NA (Not Applicable) or NO, as appropriate. Thank you.

Ernesto Michelucci, Ph.D.

Referred by:________________________________ Today's Date:________________________

Name: ____
First Middle Last

Address: ____

____ **Zip Code:**________________

Date of Birth:______________________ **Social Security No.:**___________________________

Telephone Nos.: Home:_______________ Work:_______________ Pager:__________________

Marital Status:_____________ Name of spouse or significant other:________________________

Time together____

If you have children, please complete the following:

Name: ____________________________________ Age:_______ Living with you?____________

Name: ____________________________________ Age:_______ Living with you?____________

Name: ____________________________________ Age:_______ Living with you?____________

Employer:____________________________**Occupation:**_________________________________

Medical Insurance (1st):_____________________ **Contract No**: ___________________--_____

Medical Insurance (2nd):_____________________ **Contract No**:____________________--_____

Primary Care Physician (PCP):____

PCP's address & Phone No.:____

When was your last **complete** physical examination?____________________________________

When did you **last** see your Primary Care Physician?____________________________________

Please check any of these medical conditions that apply to you:

[ ] Heart Disease [ ] Hypertension [ ] Asthma/Respiratory [ ] Stomach/GI Problems
[ ] Liver Disease [ ] Renal Disease [ ] Cancer [ ] Head Injury [ ] Seizures/Epilepsy
[ ] Neurological Disorder [ ] HIV+/AIDS [ ] Visually Impaired [ ] Hearing Impaired
[ ] Other ____

What medications are you currently taking: (Please be as accurate as possible and add separate list if necessary)

Name: ____________________ Dosage:________________________ How long?___________

Name: ____________________ Dosage:________________________ How long?___________

Name: ____________________ Dosage:________________________ How long?___________

Name: ____________________ Dosage:________________________ How long?___________

What medications did you take **in the past** to treat depression, anxiety, or other psychological

distress?____

____

*Please list all medications or substances that you are allergic to:

____

For Women:

Gynecologist's Name**:** ______________________________ Phone No.: ____________

Date of last gynecological examination**:** _______________________________________

Do you have any particular difficulties with menstruation or ovulation? If so, please

describe: ____

____

Please list all the **medical specialists** that you have seen over the last 5 years: ____________

____

How many hours of sleep do you **normally** average per night?___________________________

Do you have trouble falling asleep?___________________ staying asleep?_________________

How many hours of sleep have you been averaging **recently**? ___________________________

What time have you been awakening in the morning **recently**?__________________________

Do you exercise? _________ If so, what type of exercise and how often? __________________

____

Do you have difficulty with sexual relations?__________ Please describe:________________

____

____

Do you drink coffee, tea, or caffeinated sodas? _____________________________________

If so, how much per day? ____

Do you currently smoke cigarettes? ________ If so, how many a day?____________________

Did you previously smoke cigarettes? ________ When did you quit? _____________________

Do you currently smoke marijuana? ________ How often? _____________________________

Did you previously smoke marijuana? ________ When did you quit? _____________________

Have you ever used cocaine, heroine, or other street drugs? ___________________________

Last time used: ____

Do you drink beer? ________ If so, how much per day on the days you drink? ______________

____

How many days per week? ____

Do you drink wine? ________ If so, how much per day on the days you drink? ______________

____

How many days per week? ____

Do you drink other alcoholic beverages (e.g., liquor, etc.)? ____________________________

If so, how much per day on the days you drink? _____________________________________

How many days per week? ____

Have you ever wondered if you had a problem with drugs or alcohol? ____________________

____

Your current height: ______ft.______inches. Current weight:____________________________

Highest adult weight: ________________ Lowest adult weight:___________________________

Do you diet? _____________ How frequently? ____

Do you consider yourself to have a weight problem? ______________________________________

Did you finish high school?_________ Year of graduation:___________________________________

What was high school like for you? ____

Did you attend college? _________ Where and when: ______________________________________

____

____

Highest degree earned: __________________________________ Year:_______________________

Have you ever been physically assaulted? __________ Please describe: _____________________

____

____

Have you ever been forced to engage in undesired sexual activity? ________________________

Please describe: ____

____

____

Have you ever been in any legal difficulty? _______________ When? _______________________

Please describe: ____

____

Family History

Mother's name: ____ Age: ________________

If deceased: When deceased: ____________ Cause: _______________________________

Mother's city of residence: ____

Mother's occupation: ____

Father's name: ____ Age: ________________

If deceased: When deceased: ___________ Cause: _____________________________

Father's city of residence: ____

Father's occupation: ____

Parents' marital status: ___________________________ How long? _____________________

Siblings:	Name	Occupation	Age
	______________________	_________________________	__________
	______________________	_________________________	__________
	______________________	_________________________	__________
	______________________	_________________________	__________

Did any member of your family have difficulty in any of the following areas? If so, please indicate **who**:

Learning Problems/ADHD: ____

Alcohol & Drug Abuse: ____

Depression and/or Anxiety: ____

Serious Medical Problem(s): ____

Has any other member of your family sought counseling? ________________________________

If so, please indicate who: ____

Has anyone close to you ever died? ________ If so, who and when? ______________________

____

____

Has anyone close to you ever committed suicide? If so, who and when? __________________

____

____

Treatment History:

Have you worked with a therapist / counselor / psychologist / psychiatrist before?____________

If so, when? ______________________ For how long?___________________________________

Clinician's name: ____

Problem at the time: ____

Have you ever received treatment for alcoholism or drug abuse, including a detoxification program?__________ If so, when?____

Name of agency or hospital: ____

Have previously received **in-patient** treatment in a hospital for depression, anxiety, or other psychological distress?_________ If so, when was the **last** time?___________________________

For how long? _____________________ Name of hospital: _______________________________

Approximate dates of other in-patient treatments (if any): __________________________________

____

What kind of help do you expect to receive from your counseling sessions? _________________

____

____

How long do you think it will take to receive the help you want? ____________________________

____

Please indicate below any further comments or information you would like me to know: ________

____

____

____

____

Your signature