Peninsula Behavioral Health

providing evidence-based psychotherapy to the bay area

Dana Steidtmann, Ph.D.
Clinical Psychologist
(650) 397-1610
518 Hamilton Avenue
Palo Alto, CA 94301

CA License: 24591
dana@penbh.com

BACKGROUND FORM

Preferred name: ______________________________________

Preferred contact number: ____________________ This number is for: CELL HOME WORK

Okay to leave a message about appointments and scheduling at this number? Y N
Okay to leave a message about clinical issues at this number? Y N

Gender: ____________________________________ Age: _______________________________________

Ethnicity: ___________________________________ Sexual Orientation: __________________________

Occupation: _______________________________ Highest level of education: ____________________

Address: ___________________________________ Referred by: _______________________________

____ May I acknowledge referral?: Y N

Email: _____________________________________ Relationship Status: _________________________

Years in relationship: ___________________

Have you been in psychotherapy before? Y N
If yes, when? _________________________________

Are you currently receiving psychiatric or mental health services elsewhere? Y N
If yes, where? ________________________________

Do you have any medical conditions or difficulties? Y N
If yes, please list: _____________________________

Are you currently taking any medications? Y N
If yes, please list: _____________________________

Do you consume alcoholic drinks? Y N
If yes, how often? ____________________________

Please list three things that are important to you in your life: ____

____

____

Peninsula Behavioral Health

providing evidence-based psychotherapy to the bay area

Below is a list of common challenges people face. Please **check** any that apply to you currently. **Circle** the three that currently bother you most.

Anxiety

___ Frequent worry
___ Obsessive Thinking
___ Specific fears/phobias
___ Compulsive behaviors
___ Panic Attacks
___ Social Anxiety

Mood

___ Sadness or depression
___ Mania
___ Thoughts of suicide
___ Anger or irritability
___ Loss of energy/fatigue
___ Mood swings
___ Loss of pleasure in life
___ Emotionally overwhelmed

Sleep

___ Trouble falling/staying asleep
___ Trouble waking up
___ Sleepiness during the day

Cognitive

___ Trouble concentrating
___ Racing thoughts
___ Memory problems

Interpersonal

___ Recent breakup/ separation/divorce
___ Shyness
___ Trouble maintaining relationships
___ Family problems
___ Relationship/marital difficulties
___ Difficulties with assertiveness

Identity

___ Career choices
___ Body image concerns
___ Self esteem
___ Cultural concerns
___ Personal values
___ Sexuality

Other

___ History of abuse (emotional, physical, sexual)
___ Financial problems
___ Traumatic experience
___ Other: ______________________
___ Problems with job/school
___ Legal situation
___ Medical problem(s)
___ Problems with alcohol or drugs
___ Grief or loss
___ Racism/discrimination

Please put a check in the column if your family members have or had any of the following:

	Mother	Father	Sibling(s)	Grandparent(s)
Depression				
Anxiety				
Schizophrenia				
Bipolar Disorder				
Problems with drugs or alcohol				

If there is anything else that you would like Dr. Steidtmann to know or ask about, please briefly describe here:

____

Thank you for taking the time to complete this form