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Peninsula Behavioral Health

*Providing Evidence-Based Psychotherapy to the San Francisco Bay Area*

# 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: _____

_____

Below is a list of common challenges people face. Please *check* any that apply to you currently and *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

Below, please check 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. Schulz-Heik to know or ask about, please briefly describe here:

_____

_____

*Thank you for taking the time to complete this form*