Lisa K. Willis, Ph.D., CGP

Licensed Clinical Psychologist
(585) 454-9448

First Appointment Information

Last name:_____ First name:_____ Middle initial:_____

Gender: _____ Age:_____ Date of birth:_____

Marital status:_____ Partner name & # years together _____

Mailing Address_____

Email Address_____

Home phone:_____ Work phone:_____ Cell phone:_____

Please star (*) any numbers above at which I can leave a detailed message

If you are currently employed: Occupation_____Employer_____
If applicable: Partner's Occupation_____ Employer_____

Please list 2 Emergency contacts: name, relationship to you and phone numbers:
_____

If referred by whom (name and relationship to you)_____

Please describe your main reasons for seeking help at this time and what is motivating you to enter psychotherapy _____
_____

What would you like to work on or see change as a result of psychotherapy?
_____
_____

What symptoms or issues are you experiencing? (circle all that apply):

eating/appetite anger/irritability fatigue/lack of energy restlessness loneliness gender identity sexual identity sexual concerns relationship problems depression anxiety/nervousness fears/worries low motivation/apathy self-harm loss of loved one/grief difficulty with assertiveness lack of boundaries stress arguing/fighting moody nightmares sleep difficulties alcohol/drug use financial problems obsessive thoughts compulsive behavior impulsivity social withdrawal health concerns adjustment to illness rape/sexual assault panic attacks low self-esteem/worthlessness difficulty making decisions distractibility problems with work/school suicidal thoughts/behaviors self harm concerns about weight communication problems traumatic experience headaches backaches disturbing/unwanted thoughts adjustment concerns safety concerns other_____

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Have you experienced unwanted sexual attention/activity? YES NO NOT SURE

Do you have history of sexual, physical or emotional abuse? YES NO NOT SURE

Have you experienced domestic violence? YES NO NOT SURE

Have you experienced a violent or otherwise traumatic event? YES NO NOT SURE

Do you have a history of suicide attempts? YES NO NOT SURE

Do you have a history of self harm (not intended to kill yourself)? YES NO NOT SURE

Any other current Mental Health providers (name, contact information, what they are treating you for, how frequently you see them)_____

_____

Have you had any past mental health treatment providers? If so dates and reason for treatment_____

_____

Have you ever been hospitalized for a mental health or psychiatric issue? If so please list the year, hospital name and location and specific reasons for the hospitalization_____

_____

Do you have any medical or physical problems? If so please describe:_____

Medical specialists involved in your care (list name, contact information & specialty):

_____

_____

_____

Current prescription medications:

Name Dosage Started Taking Prescribed By Purpose

_____

_____

_____

_____

_____

Over the counter medications/vitamins/supplements:

Name Dosage Started taking Purpose

_____

_____

_____

Adverse reactions/Allergies to medications or other substances _____

Any other allergies_____

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How often do you use products with caffeine? (specify type and amount and frequency)

_____

How often do you drink alcoholic beverages? (specify type and amount and frequency)

_____

How often do you smoke cigarettes? _____ If daily, how many per day?____

How often do you smoke Marijuana?_____

How often do you use any other illegal/illicit drugs? (specify type and amount and frequency)_____

How often do you use prescription or OTC medication in a manner NOT prescribed by your own doctor? (specify type, amount and frequency)_____

Please share any past history of drug use _____

Have you ever wondered if you have a problem with alcohol or drugs? YES NO

Has anyone else ever suggested that you might have a drug or alcohol problem? YES NO

How often do you engage in "high risk" sexual behavior? (please explain) _____

_____

Did you finish high school? YES NO ; If NO, how come?_____

Did you attend post high school training or schooling? YES NO ; If so, specify what type completed. Please also list non completed programs and reason for not completing

_____

Have you ever been in legal difficulty? If so what circumstances and when?_____

_____

Have you lost any person or any pet close to you? If so who, when and under what circumstances? _____

_____

Who lives in your current household? (Name, age and relationship to you)

_____

_____

_____

_____

_____

_____

_____

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Other immediate family members not currently living with you (spouse, siblings, children or parents) _____

_____

_____

Family you grew up in : Parents (including step-parents) and siblings: Please include Name, Age (year if deceased), education and occupation

_____

_____

_____

_____

_____

_____

_____

If a family member has ever been treated for emotional difficulties, mental health or psychiatric issues, please explain:_____

If anyone in your immediate or extended family has attempted or committed suicide, please explain_____

If you have you ever had concerns about the alcohol or drug use of someone close to you please explain_____

Anything else you want me to know?_____

_____

_____

_____

Signature and date

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