DODINI
BEHAVIORAL HEALTH

PATIENT INFORMATION FORM

Welcome to Dodini Behavioral Health.
Please complete as much or as little of this form as you like.
The information you choose to share will remain confidential.

Name: _____ Age: _____

DOB: _____ Gender: _____

Local Address: _____

Birthplace: _____ Hometown: _____

Preferred Phone: _____ Cell Home Work OK to leave msg? Y N

Secondary Phone: _____ Cell Home Work OK to leave msg? Y N

Email Address: _____ OK to email? Y N

Emergency Contact (name, phone, relation): _____

Health Insurance Provider: _____ Do you intend to seek out-of-network reimbursement? Y N

How did you find out about us? Referral Source: _____ Website: _____

REASON FOR SEEKING TREATMENT:

_____

_____

_____

WHEN DID THESE CONCERNS BEGIN?

_____

CURRENT ISSUES OF CONCERN: Please put a checkmark next to the items that concern you at this time, and circle the items that are most important:

__ Abortion
__ Abuse – emotional, physical verbal, sexual, neglect
__ Academic issues
__ Advisor/faculty concern
__ Aggression/violent behavior
__ Alcohol use
__ Anger, arguing
__ Anorexia/Restrictive eating
__ Anxiety, nervousness
__ Binge eating
__ Breakup
__ Body image/weight
__ Career concerns, choices
__ Childhood issues (yours)
__ Children/parenting concerns
__ Compulsive behaviors
__ Compulsive exercise
__ Computer excessiveness
__ Concentration difficulties
__ Decision making, indecision
__ Depression, sadness, crying
__ Depression, sadness, crying
__ Divorce, separation
__ Drug use
__ Eating problems
__ Emptiness
__ Family relationships
__ Fearing failure
__ Fears, phobias
__ Financial problems
__ Gambling
__ Gender identity
__ Grief/Bereavement
__ Guilt
__ Hallucinations
__ Harassment
__ Health, medical concerns
__ Identity issues
__ Impulsive behavior
__ Independence from parents
__ Infertility
__ Irresponsibility
__ Learning disability
__ Laxative use
__ Legal problems
__ Loneliness
__ Memory problems
__ Miscarriage
__ Mood swings
__ Motivation
__ Overly responsible for others
__ Overly sensitive to rejection
__ Panic attacks
__ Procrastination/time mgmt.
__ Perfectionism
__ Purging/self-induced vomiting
__ Peer relationship concerns
__ Pregnancy
__ Prejudice/bias concerns
__ Racial/ethnic concerns
__ Repeated troubling thoughts
__ Relationship concerns
__ Relationship violence
__ Religious/spiritual concerns
__ Romantic relationship
__ Self-injury, mutilation
__ Self-neglect, poor self-care
__ Sexual dysfunction
__ Sexual assault
__ Sexual concerns
__ Sexual harassment
__ Sexual orientation/identity
__ Sexually transmitted infection
__ Shame
__ Shyness
__ Sleep problems
__ Smoking, tobacco use
__ Stress
__ Suicide attempts
__ Suicidal thoughts
__ Tiredness, fatigue
__ Violent thoughts
__ Withdrawal, isolating
__ Worthless feeling
Other: _____
Other: _____

HEALTH:

Primary Care Provider (name, phone number, date of last appointment):

_____

Current Psychiatrist (name, phone number, date of last appointment):

_____

Current psychiatric medications (please include dosages): _____

_____

Past psychiatric medications (please include dosages): _____

_____

Other current medications (please include dosages): _____

_____

Have you ever been given a psychiatric diagnosis/es? ___ yes ___ no

Please list all previous diagnoses:

_____

_____

Have you ever been participated in therapy in the past? ___ yes ___ no

Please list dates of treatment and presenting concerns:

Dates: _____ Reason for treatment: _____

_____

Dates: _____ Reason for treatment: _____

_____

Have you ever been hospitalized for psychiatric illness? ___ yes ___ no

Dates: _____ Reason for treatment: _____

Dates: _____ Reason for treatment: _____

SUICIDALITY: Please check all that apply:

___Current suicidal thoughts ___History of suicidal thoughts ___History of suicide attempts
___Never had suicidal thoughts ___Current self-injury ___History of self-injury

Please list significant medical history (chronic conditions, accidents, major illnesses, surgeries):

_____

_____

_____

FAMILY:

Please list family members and any significant others (including names, relationship to you, age, location of residence, occupation, and whether you intend to include him/her in your treatment):

_____

_____

_____

_____

_____

_____

Please list significant family mental health history:

_____

_____

EDUCATION AND EMPLOYMENT:

Please list current and recent significant employment (position, company, location, and timeframe), and education (school, degree, location, and timeframe):

_____

_____

_____

_____

OTHER:

Please share anything else that you would like me to know about you:

_____

_____

_____

_____

_____

_____

Signature _____ Date _____