



# Quail Hollow Psychotherapy PLLC

Joseph L. Price, PhD

401 Discovery View Drive | Sequim, Washington 98382 | 360.683.4818

## Patient Information

Patient name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone numbers *with area code* Home: ( ) \_\_\_\_\_

Work: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_ Social Security Number: \_\_\_\_\_

Employer: \_\_\_\_\_

Position: \_\_\_\_\_ For how long? \_\_\_\_\_

Education: \_\_\_\_\_

Marital/relationship status: \_\_\_\_\_ Significant other's name: \_\_\_\_\_

Significant other's age and sex: \_\_\_\_\_ How long together? \_\_\_\_\_

Names and ages of all children in the home: \_\_\_\_\_

How did you hear about Dr. Price? \_\_\_\_\_

Who shall may be contacted in case of emergency?

Name: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

In this box, please indicate the address and telephone number you want us to use when we need to contact you. If this box is left blank, we will use the address and any of the telephone numbers you have provided above.

If you do *not* want us to leave a message on your answering machine, please tell us how you want us to reach you by phone:



List all therapists you have seen, and dates you saw them: \_\_\_\_\_

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List any substance abuse treatment or inpatient psychiatric treatment you have had, and the dates: \_\_\_\_\_

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**Please indicate which of these substances, if any, you currently use:**

<b>Substance</b>	<b>Amount used</b>	<b>How often?</b>
Cigarettes		
Alcohol		
Pills not prescribed for me		
Marijuana		
Cocaine or crack		
LSD		
Heroin		
Other (please list):		

**What kind of problem brings you to Dr. Price?**

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**Please indicate if you are having any of the following problems, or if you had them in the past:**

	<b>I have this now</b>	<b>I had it in the past</b>
<u>Difficulty falling asleep or staying asleep</u>	_____	_____
<u>Sleeping too much</u>	_____	_____
<u>Change in appetite, weight loss, or weight gain</u>	_____	_____
<u>Frequent crying</u>	_____	_____
<u>Panic attacks or anxiety attacks</u>	_____	_____
<u>Thoughts of killing or hurting myself</u>	_____	_____
<u>Attempts to kill or hurt myself</u>	_____	_____
<u>Problems concentrating</u>	_____	_____
<u>Problems remembering things</u>	_____	_____
<u>Periods of daily sadness lasting more than two weeks</u>	_____	_____

I startle easily	_____	_____
Can't stop remembering upsetting past events	_____	_____
Difficulty controlling my temper	_____	_____
I physically hurt other people	_____	_____
I break things sometimes	_____	_____
I worry a lot	_____	_____
Little or no interest in sex	_____	_____
I feel tired almost every day	_____	_____
Feelings of unreality	_____	_____
Made myself throw up in order to lose weight	_____	_____
Used laxatives or exercised excessively to lose weight	_____	_____
I often feel like I am an outsider	_____	_____
Sexual problems	_____	_____
Worry that something is wrong with my body	_____	_____
Frequent arguments with the people I live with	_____	_____
I hear voices inside my head	_____	_____
I drink too much alcohol	_____	_____
Other (please list):		

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\_\_\_\_\_

I hereby give my consent for Dr. Price to provide evaluation and psychotherapy to me.

\_\_\_\_\_

Signature

Date