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: _____

E-mail address: _____

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:

Medical History

List any allergies you have: _____ None_____

Primary Care Physician: _____Address:_____

City:_____ State:_____ ZIP:_____

Primary Care Physician's phone number: (____) _____

Date of your most recent physical examination: _____

May Dr. Price discuss your care with your primary care provider? [] Yes [] No

Please list all current medications and dosages:

Name of Medication	Dosage	Name of Prescribing Doctor	When did you start taking it?

Please list all current or past health problems, and any major operations:

Current	Past

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

_____

_____

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

_____

_____

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

Substance	**Amount used**	**How often?**
Cigarettes		
Alcohol		
Pills not prescribed for me		
Cannabis		
Cocaine or crack		
LSD		
Heroin		
Other (please list):		

What kind of problem brings you to Dr. Price?

_____

_____

_____

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

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

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):

_____

_____

_____

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

_____

Signature Date