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COMPREHENSIVE PSYCHOSOCIAL/HEALTH HISTORY

First Name: _____ Middle Initial: _____

Last Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Email Address: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____

Occupation: _____

In Case of Emergency Contact: _____

Relationship & Phone: _____

I am seeking services in (please circle all that apply):
Psychotherapy/Biofeedback/Life Coaching/EFT/Acupuncture/Herbal Medicine

I am interested in learning more about (please circle all that apply):
Psychotherapy/Biofeedback/Life Coaching/EFT/Acupuncture/Herbal Medicine

Relevant Physicians/Specialists/Practitioners:

Name_____Address_____Phone_____

Name_____Address_____Phone_____

Name_____Address_____Phone_____

* I _____ hereby grant Dr. Deborah Barbiere permission to provide and obtain information regarding my medical and psychological condition, progress and treatment from the providers listed above.

Signature_____ Date_____

Reason for Today's Visit:

_____

_____

_____

How, when & where did this condition begin?

_____

_____

_____

_____

_____

What other forms of treatment have you sought?

_____

_____

_____

Please list any other psychological/emotional/behavioral/health issues you'd like to address in order of importance (ex. insomnia, headaches/migraines, weight loss, digestive issues, acne, drug use, etc)

1. _____
2. _____
3. _____

Your Medical History:

Surgeries, Major Illnesses, Hospitalizations, and Major Accidents:

_____

_____

_____

Current Medications, Supplements, and Vitamins (and what theyr are for):

_____

_____

_____

_____

_____

SOCIAL/BEHAVIORAL HISTORY

Tobacco Use
Cigarettes: ____Never _____Quit (date_____)
_____Current Smoker (packs/day_____ # of years____)
Other Tobacco: _____Pipe _____Cigar _____Snuff _____Chew
Are you interested in quitting? YES/NO

Alcohol Use
Do you drink alcohol? YES/NO # of drinks/week_____
Is your alcohol use a concern for you or others? YES/NO

Drug Use
Do you use any recreational drugs? YES/NO
Have you ever used needles to inject drugs? YES/NO

Sexual Activity
Sexually active: YES/NO/NOT CURRENTLY
Current sex partner(s) is/are: MALE/FEMALE
Birth control method:_____
Have you ever had any sexually transmitted diseases (STDs)? YES/NO

Caffeine Intake: _____ None _____Coffee/Tea/Soda (_____cups/day)

Weight: Are you satisfied with your weight? YES/NO

Diet: How do you rate your diet? GOOD/FAIR/POOR
Do you take any dietary supplements? YES/NO (please explain)

_____

Exercise: Do you exercise regularly? YES/NO
What kind of exercise?_____
How long (minutes)?_____ How often?_____
If you do not exercise, why?_____

Safety:
Is violence at home a concern for you?_____
Have you ever been abused?_____

How do you FEEL about the following areas of your life?
*Please **circle** any of these areas you'd like to address in your treatment.*

	Great	Good	Fair	Poor	Bad	Problems you may be experiencing
Significant other	____	____	____	____	____	_____
Family	____	____	____	____	____	_____
Diet	____	____	____	____	____	_____
Sex	____	____	____	____	____	_____
Self	____	____	____	____	____	_____
Work	____	____	____	____	____	_____
Exercise	____	____	____	____	____	_____
Spirituality	____	____	____	____	____	_____

If you are interested in **EASTERN MEDICINE MODALITIES** (Acupuncture, Herbal Medicine, etc), or would like to know how these treatments may apply to you, please complete the next pages:

Body Systems Review (please check all that apply)
0=never 1=in the past but not now 2=occasionally 3=frequently 4=almost always

0 1 2 3 4	low or excessive appetite	0 1 2 3 4	heavy limbs
0 1 2 3 4	loose stools	0 1 2 3 4	fatigue
0 1 2 3 4	abdominal gas/bloating after food	0 1 2 3 4	hemorrhoids
0 1 2 3 4	fatigue after eating	0 1 2 3 4	belching
0 1 2 3 4	organ prolapsed	0 1 2 3 4	nausea
0 1 2 3 4	bruise easily	0 1 2 3 4	diarrhea
0 1 2 3 4	obsessive thoughts/worrying	0 1 2 3 4	craving for sweets

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0 1 2 3 4	spontaneous sweat	0 1 2 3 4	feeling of sadness
0 1 2 3 4	allergies	0 1 2 3 4	catch colds easily
0 1 2 3 4	asthma	0 1 2 3 4	feel tired after exercise
0 1 2 3 4	shortness of breath	0 1 2 3 4	general weakness
0 1 2 3 4	cough	0 1 2 3 4	nasal discharge
0 1 2 3 4	dry nose/mouth/skin/throat	0 1 2 3 4	sinus congestion

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0 1 2 3 4	sore, cold or weak knees	0 1 2 3 4	feeling cold
0 1 2 3 4	low back pain	0 1 2 3 4	edema
0 1 2 3 4	frequent urination	0 1 2 3 4	hair loss
0 1 2 3 4	urinary incontinence	0 1 2 3 4	memory loss
0 1 2 3 4	ear problems	0 1 2 3 4	hot flashes
0 1 2 3 4	early morning diarrhea	0 1 2 3 4	nightsweats
0 1 2 3 4	craving salt	please circle: high low normal libido	

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0 1 2 3 4	irritable	0 1 2 3 4	muscle spasms/twitches
0 1 2 3 4	feel better after exercise	0 1 2 3 4	heartburn/acid reflux
0 1 2 3 4	tight feeling in chest	0 1 2 3 4	dry eyes/red eyes
0 1 2 3 4	alternating diarrhea/constipation	0 1 2 3 4	ear ringing
0 1 2 3 4	symptoms worse with stress	0 1 2 3 4	anger easily
0 1 2 3 4	neck/shoulder tension	0 1 2 3 4	sand in eyes
0 1 2 3 4	floaters in vision	0 1 2 3 4	hair loss
0 1 2 3 4	brittle or weak nails	0 1 2 3 4	frequent headaches
0 1 2 3 4	feeling of heat rushing to head	0 1 2 3 4	blurry vision
0 1 2 3 4	difficulty making plans or decisions	0 1 2 3 4	gall stones

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0 1 2 3 4	feel heart beating	0 1 2 3 4	chest pain
0 1 2 3 4	insomnia	0 1 2 3 4	disturbing dreams
0 1 2 3 4	sores on tip of tongue	0 1 2 3 4	excessive laughter
0 1 2 3 4	anxiety	0 1 2 3 4	palpitations
0 1 2 3 4	restlessness	0 1 2 3 4	excessive sweat
0 1 2 3 4	red cheeks	0 1 2 3 4	nightmares

Continue to next page 

Urination (please circle all that apply): Burning Urgent Retention Frequent
Scanty Profuse Dribbling
Cloudy Dark Pale

Bowel Movements: Frequency_____ When? _____

Feels Complete? Yes No

Consistency: Well-formed Hard Loose Alternates

In stools? Undigested food Blood Mucus

Are you thirsty? Yes No If so do you crave warm or cold drinks? _____

Do you find that you "run" particularly hot or cold? _____

How is your energy in general? _____

Do you often get headaches or migraines? Yes No

If yes where do you feel the pain? _____

Are they dull and aching OR sharp and stabbing in nature? _____

When do you normally get them? _____

How do you feel emotionally right now? _____

Describe what you eat: _____

Sleep: Hours per night _____ Time to bed _____ Time to rise _____

Rested in AM? Yes No Trouble falling asleep? Yes No Sometimes

Waking up at night? Yes No Get up to urinate more than once? Yes No

Work: Enjoy work? Yes No Hours per week working _____

Continue to next page 

For Women:

Age of 1st period_____ Are you pregnant? Y/N # of pregnancies_____
Age of last period (menopause) ___ # of: live births___ abortions___ miscarriages___
# of Days between periods___ Date of last: Gyn exam_____ Pap Smear_____
# of Days of flow___ Mammogram_____ Bone Density Scan_____
Color of flow_____ Results:_____
Clots? Y/N Color_____ _____
Have you been diagnosed with: ___Fibroids ___Fibrocystic Breasts ___Endometriosis
___ Ovarian cysts ___PID Other_____
Location of pain: ___Lower abdomen ___Lower Back ___Thighs ___Other_____
Nature of Pain (please indicate before, during or after menses)
Cramping_____ Stabbing_____ Burning_____ Aching_____ Dull_____
Bloating_____ Consistent_____ Intermittent_____ Bearing Down_____

Other symptoms related to menses:

___ discharge	___ vaginal dryness	___ headache
___ nausea	___ constipation	___ diarrhea
___ swollen breasts	___ mood swings	___ ravenous appetite
___ poor appetite	___ hot flashes	___ night sweats
___ increased libido	___ decreased libido	___ insomnia

For Men:

Date of last prostate check up_____ PSA results _____ Manual exam results_____
Lab results_____
Frequency of Urination: day____ night_____ Color of urine: __clear __murky Odor:_____

Symptoms related to prostate:

___ prostate problems	___ groin pain	___ incontinence
___ back pain	___ dribbling	___ premature ejaculation
___ delayed stream	___ decreased libido	___ retention of urine
___ increased libido	___ testicular pain	___ impotence

If you are interested in **BIOFEEDBACK/NEUROFEEDBACK**, or would like to know how these treatments may apply to you, please complete the next pages:

1. Prior experience with relaxation therapies

2. Prior experience with breathwork

3. Prior experience with biofeedback or neurofeedback

4. Prior experience with meditation, what form?

5. Neurocognitive factors (CIRCLE ANY RELEVANT PROBLEMS)

*Memory
*Attention/Concentration
*Academic Challenges (IQ, Learning disabilities, language…)
*Work Challenges
*Head/Brain injuries or surgeries
*Language/Communication

6. Physical factors (CIRCLE ANY RELEVANT PROBLEMS)

*Circulatory issues
*Cold hands/feet
*Muscle pain/spasm
*Joint pain

7. Are you multilingual? Y/N If so what languages do you speak?

8. Hand Dominance R/L

9. How do you relax now?

   Is it effective?

10. How is you sleep (please explain)?

11. Hobbies/Interests:

THANK YOU, WE LOOK FORWARD TO YOUR VISIT!