PAMELA G. KRONES, PH.D.
LICENSED PSYCHOLOGIST

1550 MADRUGA AVENUE, SUITE 323
CORAL GABLES, FL 33146
305-284-0878
WWW.DRPAMELAKRONES.COM

CLIENT HISTORY FORM

Please print this form, complete it, and bring it to your first appointment. The information that you provide is confidential and will not be given to anyone without your written permission.

Personal History

Name:_____ Today's Date:_____

Date of Birth: _____ Gender: _____ Age: _____

Racial-Ethnic or Cultural Background: _____

Religious/Spiritual Affiliation or Orientation:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address:_____

Home Phone #: _____ Cell Phone #: _____

May I leave a message on your voicemail or answering machine?

Home Phone: ☐Yes ☐No
Cell Phone: ☐Yes ☐No

In case of emergency, whom may I contact?

Name:_____ Phone #: _____

Relationship to you? _____

Family and Living Arrangements

Family/Significant Others

Please complete the table below for all family members, relatives, and other individuals who live in your home or are an important part of your life. Indicate the person's relationship to you (e.g., mother, stepfather, boyfriend, sister, grandmother, roommate), his or her age, whether he or she is currently alive, and whether he or she lives with you.

Relationship	Name	Age	Alive?	Lives with you?

What is your current living situation?

Please describe any recent family or living arrangement changes or stressors (e.g., moving, marriage, divorce, death of a family member or friend)

Social Functioning

Are you currently involved in a romantic relationship? If so, how long have you been in this relationship?

Are there any problems or stressors in your romantic relationship? If so, please describe.

Are you experiencing any problems or stressors with friends, classmates, or peers? If so, please describe.

Please describe any recent changes in your social functioning (e.g., feeling lonely, withdrawing from friends, arguing with people)

Please list your hobbies and personal interests.

Please list any clubs, teams, social or spiritual organizations, or other extracurricular activities in which you participate.

Education

Are you currently in school? ☐Yes ☐No

If yes, what school do you attend?

What is your current year in school?

What is your major?

What is your grade point average?

Please describe any recent changes in your school performance (e.g., absences, tardiness, increased or decreased productivity, difficulty concentrating, conflicts with peers)

Please list all schools, colleges, and universities you have attended, including majors, degrees earned, and dates of graduation.

Institution	Major and Degree Earned	Graduation Date

Employment

Do you currently have a job? ☐Yes ☐No

If yes, where do you work?

What is your job title?

How many hours per week do you work?

How long have you been employed?

Please describe any recent changes in your job performance (e.g., absences, tardiness, increased or decreased productivity, difficulty concentrating, conflicts with coworkers).

Medical Information

Please list any current health concerns, medical illnesses, conditions, or disabilities.

Have you ever been hospitalized? If so, please list the dates and reasons for the hospitalizations.

Have you ever had surgery? If so, please list the dates and reasons for surgery.

Please list all current medications that you are taking for any reason, including medicine for medical or mental health conditions, birth control pills, vitamins, and supplements.

Please place a checkmark if you have been experiencing any recent changes in the following:

_____ Eating patterns	_____Appetite	_____ Weight
_____ Sleep patterns	_____Energy level	_____ Physical activity level
_____ General disposition	_____Behavior	_____ Nervousness/tension

Please describe changes in the areas in which you checked above.

Lifestyle Information

In general, how many hours do you sleep each night during weekdays and weekends?

Weekdays_____ Weekends_____

In general, how would you describe your eating habits (e.g., excellent, good, poor, healthy, unhealthy, junk food)?

Do you exercise? If yes, what do you do and how often?

Do you consume caffeine? If yes, how much and how often?

Please describe what you do for fun and how often you engage in these activities.

Mental Health Information

Have you ever been diagnosed with a mental or emotional problem, such as depression, anxiety, ADHD, bipolar disorder, or an eating disorder? If so, please describe.

Please describe any previous experiences with psychotherapy or other mental health treatment, including dates, name of providers, and outcome.

Do you have any learning disabilities or other special needs? If so, please describe.

Has anyone in your family been diagnosed with or treated for mental or emotional problems? If so, please list the family member(s), the type of problem, and approximate date(s).

Why are you seeking psychotherapy at this time?

Please describe any problems or symptoms you are currently having (for example, insomnia, depression, trouble concentrating, panic attacks, negative thoughts about yourself, relationship problems).

What are your goals for therapy?

Referral Source

PsychologyToday.com: _____ Person: _____

NetworkTherapy.com: _____ Other (please specify): _____