Fishbein & Associates
Performance Consulting

DATE: _____

(FAMILY DEMOGRAPHICS)

CLIENT:

NAME: _____ AGE: _____ BIRTHDATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL: _____

FOR CLIENTS UNDER AGE 18:

MOTHER'S NAME: _____ AGE: _____

MOTHER'S PHONE: (H) _____ (C) _____

MOTHER'S EMAIL: _____ OCCUPATION: _____

FATHER'S NAME: _____ AGE: _____

FATHER'S PHONE: (H) _____ (C) _____

FATHER'S EMAIL: _____ OCCUPATION: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SIBLINGS:

NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT

(FAMILY DEMOGRAPHICS CONT.)

MARITAL STATUS OF PARENTS: (Circle One) Married Separated **Divorced*** Widowed

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***If Divorced:** Custody: _____

Visitation: _____

Child's Main Residence: _____

Divorce Agreement: _____

(EDUCATION)

SCHOOL: _____ GRADE: _____ PHONE: _____

SCHOOLS ATTENDED:

ELEMENTARY SCHOOL: _____
MIDDLE SCHOOOL: _____
HIGH SCHOOL: _____
COLLEGE: _____

(FAMILY MEDICAL HISTORY)

DOES THE PATIENT HAVE HISTORY OF…OR IS THERE ANY FAMILY HISTORY OF? (PLEASE NOTE RELATIONSHIP TO THE PATIENT IF THERE IS A FAMILY HISTORY):

DEPRESSION: □ YES □NO _____

BIPOLAR DISORDER OR MANIC-DEPRESSION: □ YES □NO _____

ANXIETY: □ YES □NO _____

ADHD: □ YES □NO _____

AUTISM: □ YES □NO _____

DEVELOPMENTAL DELAYS: □ YES □NO _____

SELF-INJURY: □ YES □NO _____

ATTEMPTED/COMPLETED SUICIDE: □ YES □NO _____

ALCOHOLISM/SUBSTANCE ABUSE: □ YES □NO _____

LEARNING DISABILITIES: □ YES □NO _____

PSYCHIATRIC HOSPITALIZATION: □ YES □NO _____

HEAD INJURY: □ YES □NO _____

(FAMILY MEDICAL HISTORY CONT.)

CONCUSSIONS: □ YES □NO _____

CARDIAC ARRHYTHMIA: □ YES □NO _____

OTHER HEART PROBLEMS: □ YES □NO _____

DIABETES: □ YES □NO _____

SEIZURE: □ YES □NO _____

SUDDEN DEATH: □ YES □NO _____

HIGH BLOOD PRESSURE: □ YES □NO _____

OTHER SIGNIFICANT FAMILY HISTORY: _____

_____

_____

_____

_____

PRIMARY CARE PHYSICIAN/PEDIATRICIAN

May I contact this person for the purposes of care coordination? □ YES □NO

NAME:_____OFFICE PHONE:_____

ADDRESS:_____CITY: _____STATE: _____ZIP: _____

1) CURRENT MEDICATIONS/SUPPLEMENTS/VITAMINS: (Please continue on reverse as needed)

MEDICATION NAME	DOSAGE	SCHEDULE (e.g. AM, PM)	REASON

2) ALLERGIES:_____

_____

_____

_____

_____

(ATHLETIC HISTORY)

Please let me know for what reason you are seeking out sport psychological services. Provide any background information you would like that relate to your purpose and goals for the future.

(REFERRAL SOURCE)

REFERRAL SOURCE:_____ PHONE:_____