Parkside Psychological Services
Dr. Paul Smiley
847 420 5088
paul.smiley@parksidepsych.com

IDENTIFYING INFORMATION:

Name: _____ Date of Birth: _____ Sex: ☐ M ☐ F Social Security Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ ☐ OK to leave message Cell Phone: _____ ☐ OK to leave message Work Phone: _____ ☐ OK to leave message

E-mail Address: _____ Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

PRESENTING PROBLEMS:

☐ Anxiety/Panic ☐ Social Problems ☐ Anger/Aggression ☐ Life Adjustment/Change ☐ Sexuality/Gender ☐ Behavior Issues

☐ Depression ☐ Addition/Compulsion ☐ Bereavement/Loss ☐ Family Stress/Divorce ☐ Medical Problems ☐ Legal Problems

☐ Multiple or Single Episode Trauma ☐ Relationship Problems ☐ Other: _____

PRIOR MENTAL HEALTH TREATMENT:

Have you seen a therapist before? ☐ Yes ☐ No

If yes, please describe your experience: _____

_____

Please describe any previous mental health treatment issues: _____

_____

MEDICATIONS AND TREATMENT:

Are you currently prescribed any psychiatric medications? ☐ Yes ☐ No

Current medications (if necessary, please include additional medications on the back of this page).

Reason _____ Dose/Frequency _____ Length of Use _____

Reason _____ Dose/Frequency _____ Length of Use _____

Reason _____ Dose/Frequency _____ Length of Use _____

Prescribing Doctor(s) _____ ☐ Medical ☐ Psychiatrist

_____ ☐ Medical ☐ Psychiatrist

MENTAL HEALTH:

Are you currently experiencing any suicidal thoughts? ☐ Never ☐ Rarely ☐ Sometimes ☐ Frequently

Have you ever intentionally inflicted any harm to yourself? ☐ No ☐ Yes (please explain) _____

Have you ever intentionally inflicted any harm on someone else? ☐ No ☐ Yes (please explain) _____

Have you ever been hospitalized for mental health issues? ☐ No ☐ Yes (please provide when, where, and reason) _____

_____

BRIEFLY DESCRIBE YOUR GOAL(S) FOR THERAPY:

1. _____
2. _____
3. _____