Initial Visit Form
BeBudd, PhD © 2009

BEBudd, PhD
Clinical Psychologist

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Name:______________________________ Date:______________

Phone Numbers: (H)______________ (O) ______________ (C) ______________

Email Address:______________ Age: ______________ Date of Birth:______________

Address:______________________ City:__________ Zip: ______________

Education:______________ Occupation/Employer:______________________

Others living in home: Please include ages and relationship:______________________

____

Name and Phone Number of Emergency Contact: ______________________

Alcohol Intake:__________ Drinks per Day?__________ Drinks per Week? __________

Do you smoke?__________ Wear seatbelts?__________ Eat Balanced Diet? __________

Type of Exercise you do: ______________ Frequency per Week?______________

Do you have trouble sleeping:______ Too Much? ______ Too Little?______________

Do you consider yourself healthy?______________ Have any trouble relaxing? __________

Physician's Name and Phone Number:______________________

Prescribed Medications:______________________

Medical Problems (Include diagnosis & date of onset):______________________

____

Hospitalizations (Include date & reason): ______________________

Are you in therapy now?__________ If yes, with whom? ______________________

Have you been in therapy before?______ If yes, did you consider it helpful?______________

Names of previous therapists:______________________

How did you get referred to my office? ______________________

Briefly describe the problem that brings you here for help and when you first became aware of the problem:__________

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Any other issues or concerns you want me to know:______________________