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**NOTE: THIS FORM IS OPTIONAL. YOU CAN FILL OUT AS MUCH OR AS LITTLE AS YOU WISH**

**BACKGROUND INFORMATION**

**Presenting Concerns:**

What brings you in for services? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**CURRENT PROBLEMS: How often have you experienced the following?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Problem** | **Never** | **Sometimes** | **Often** | **Always** |
| Excessive Sadness |  |  |  |  |
| Nervousness |  |  |  |  |
| Racing Thoughts |  |  |  |  |
| Low Energy |  |  |  |  |
| High Energy |  |  |  |  |
| Suicidal Thoughts |  |  |  |  |
| Sense of Hopelessness |  |  |  |  |
| Panic |  |  |  |  |
| Angry outbursts |  |  |  |  |
| Increased Appetite |  |  |  |  |
| Decreased Appetite |  |  |  |  |
| Sleep Difficulties |  |  |  |  |
| Problems related to eating |  |  |  |  |
| Hallucinations |  |  |  |  |
| Trouble Concentrating |  |  |  |  |
| Irritability |  |  |  |  |
| High anxiety |  |  |  |  |
| Worry |  |  |  |  |
| Self Abuse (i.e. cutting/burning) |  |  |  |  |

**PREVIOUS BEHAVIORAL HEALTH SERVICES: (**Such as with a Psychologist, Social Worker, Psychiatrist, Counselor or Psychological testing).

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of Treatment** | **When** | **Who treated you?** | **Were you hospitalized? Where?** |
|  |  |  |  |
|  |  |  |  |

|  |  |  |
| --- | --- | --- |
| **Current Medication** | **Dosage/Frequency** | **Prescribing Physician** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**SUBSTANCE USE: Have you ever used the following substances?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Substance** | **Current Y/N** | **Past** | **About how much?** | **About how often** | **Is this something you would like to change? Y/N** |
| Alcohol |  |  |  |  |  |
| Marijuana |  |  |  |  |  |
| Cocaine |  |  |  |  |  |
| Opiates |  |  |  |  |  |
| Amphetamines |  |  |  |  |  |
| Hallucinogens |  |  |  |  |  |

Do you use smoke cigarettes? Y N How many per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL INFORMATION:**

Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST SURGICAL HISTORY:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Past MEDICAL HISTORY: Please circle any current or past experiences with the following.**

Asthma

Shortness of breath

Chronic Pain

Chronic Cough

Fatigue

Heart Attack

Seizures

Problems with Vision

Hearing Difficulties

Numbness/Tingling

Head Injuries

Stomach Ulcer

Nausea/Vomiting

Cancer

Heartburn/Reflux

Stroke

Chronic Lung Disease

Hernia

Headaches

High Blood Pressure

Congestive Heart Failure

Weight Gain

Weight Loss

Sleep Difficulties

Diabetes

Kidney/Bladder Problems

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMPLOYMENT/EDUCATION:**

Current Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Years in field: \_\_\_\_\_\_\_\_\_

Current Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Highest level of Education attained\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently enrolled in school? Yes No

If yes, what type of education are you receiving? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT LIVING SITUATION:** Who is currently living with you?

Person Age Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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