PSYCHOLOGICAL SERVICES OF EAST LANSING, PLLC

JACQUELINE MEZZA TITUS, PH.D., LICENSED CLINICAL PSYCHOLOGIST

CLIENT APPLICATION

IDENTIFYING INFORMATION:

Full Name _____Today's Date_____
Male_____ Female_____ Date of Birth_____ Age_____
Home Address _____
City _____ State _____ Zip Code _____ Telephone _____

Is it OK to contact you at home?_____ OK to leave a message?_____ Special instructions?_____
_____

How did you learn about my services?:_____
_____

INTERNET & EMAIL

By providing your email address on this form, you authorize the office of Dr. Jacqueline Titus to store information about you and communicate with you via internet and electronic mail. While use of the internet and email has many benefits such as speed of communication ease of record-keeping, and convenience, the internet is not a secure environment and confidentiality cannot be guaranteed. Every effort is made by this office to keep you information private to the extent possible, however once information has been entered online or an email has been sent, the information may be accessed by individuals other than the intended recipients(s) and is no longer under the sender's control. Email systems often store email interactions, and emails sent from a personal computer may be readable by any individual with access to that computer. In providing an email address, it is recommended that you choose a personal one that you do not share with other individuals, although this office may reply to you via any other email address from which you may initiate a communication. You agree to keep private your email password(s) and email accounts private.

Email address:
_____

OCCUPATION/EMPLOYMENT INFORMATION:

Check all that apply: ☐ employed ☐ retired ☐disabled ☐student ☐ homemaker ☐ unemployed
If/When employed, what type of work do you do?_____
Current employer is:_____ Years on Current Job:_____
Business Phone _____ Is it OK to contact you at work? ☐ yes ☐ no
OK to leave a message? ☐ yes ☐ no Special calling instructions?_____
_____

Are you currently having difficulties on the job because of: ☐emotional problems? Or ☐ substance abuse? (Check if yes)
Have you ever had difficulties at work because of: ☐emotional problems? Or ☐ substance abuse? (Check if yes)
If yes to any of the above, please explain:_____
_____
_____

Ever in Military Service: ☐ yes ☐ no Currently in military? ☐ yes ☐ no Branch:_____
If you served in combat, when did you serve?_____
Type of discharge:_____ Reason for discharge _____
_____

MARITAL STATUS:

Marital/relationship status (Check one) ☐ Married; ☐ Live with partner (check if same ___ or opposite___ sex);
☐ Single; ☐ Separated/Divorced; ☐ Widowed; or ☐ Other: _____

If previously married, please provide dates of marriage(s):_____
Number of years currently married:_____
Are you experiencing any problems/stresses in your current marriage/relationship? ☐ yes ☐ no
Did you experience any problems/stresses in your previous marriage/relationship? ☐ yes ☐ no
Comments regarding stresses in current or previous marriage(s)/relationship(s):_____

If you have had problems in the past, what do you think caused those relationships to end?

EDUCATION:

Last grade completed in school/college is/was : _____ Degree:_____
Are you currently enrolled in school? ☐ yes ☐ no Major/focus:_____
Do you have any special training, skills, or certification? (list):_____
Do you have any problems reading or writing? ☐ yes ☐ no
How do you learn best?_____
What was school like for you?_____
Describe any difficulties or problems you had/have in school:_____

REASON FOR SEEKING TREATMENT

Please briefly describe the problems you are experiencing. I will discuss this in more detail with you shortly.

What has happened to cause you to seek help NOW?_____

What do you hope to be able to do or achieve as a result of treatment?

What do you consider to be the other stresses in your life?_____

HISTORY OF THE PROBLEM:

When did you first start experiencing the problem(s) that bring you to treatment today?_____
How often does the problem occur?_____
How long does it last?_____

Do you currently have thoughts of harming yourself? ☐ yes ☐ no
Do you current have thoughts of wishing you were dead? ☐ yes ☐ no
Do you currently have urges to hurt, harm, or kill someone else? ☐ yes ☐ no If yes, whom?_____
Have you **ever** seriously considered suicide or felt like harming someone else? ☐ yes ☐ no If yes, please explain:____

Do you have any problem with any of the following: ☐ overspending ☐ food binging ☐ intentional vomiting
☐ yelling/threatening ☐ risk taking/endangering self or others ☐ hitting, shoving, choking, or hurting others
☐ throwing or breaking things ☐ stealing ☐ internet overuse or misuse ☐ sexual feelings/behaviors
Have you ever had previous therapy/counseling of any kind? ☐ yes ☐ no If yes, when and for how long?_____

What concerns did you address in previous therapy?_____

Have you ever been hospitalized for emotional problems? ☐ yes ☐ no Or substance Abuse problems? ☐ yes ☐ no
If yes to either of the above, when, where, and for how long were you hospitalized?_____

Were any of your previous treatment experiences helpful? ☐ yes ☐ no Please explain how you benefited or did not benefit from previous treatment:_____

Have you had any experience with self-help support groups? ? ☐ yes ☐ no
If yes, please explain when, which ones, and whether or not you found them helpful:_____

SUBSTANCE USE HISTORY:

Have you ever experienced a problem with alcohol, drugs, or prescription medications? ☐ yes ☐ no
If yes, please explain:_____

Have you ever been treated for problems with alcohol, drugs, or abuse or prescription medications? ☐ yes ☐ no
If yes, please explain:_____

Has anyone (family, doctors, friends, coworkers, bosses, etc.) ever expressed concern that you might have a problem with alcohol or drugs? ☐ yes ☐ no If, yes, please explain:_____

Have you had any problems related to use of alcohol/drugs in the past year? ☐ yes ☐ no If, yes, please explain:

Has drinking or drug use ever caused you problems in the following areas (check if yes): ☐ family ☐ school
☐ employment ☐ legal ☐ emotional ☐ social ☐ financial ☐ behavior ☐ physical health
☐ other, please describe:

FAMILY BACKGROUND:

PLEASE CHECK THIS BOX IF YOU HAVE NO CHILDREN: ☐

Names of Children	Living with you?	Age	Grade	School
1.	☐ yes ☐ no			
2.	☐ yes ☐ no			
3.	☐ yes ☐ no			
4.	☐ yes ☐ no			
5.	☐ yes ☐ no			

Other than any children already indicated above, who lives in your household?

Please describe your relationships with other family members:

Relationship	Living?	Age	Frequency of contact?	Describe quality of relationship
Father	☐ yes ☐ no ☐ n/a			
Mother	☐ yes ☐ no ☐ n/a			
Step-father	☐ yes ☐ no ☐ n/a			
Step-mother	☐ yes ☐ no ☐ n/a			
Spouse/partner	☐ yes ☐ no ☐ n/a			
Sister(s)	☐ yes ☐ no ☐ n/a			
Brother(s)	☐ yes ☐ no ☐ n/a			
Other_____	☐ yes ☐ no ☐ n/a			

Whom were you raised by? Were you adopted? ☐ yes ☐ no

What family member(s) are you closest to now?

As you were growing up, what adult(s) stood out as people you could really trust?

Check the statement(s) below that describe the type of family you grew up in:
☐ overly close family ☐ no "breathing room" ☐ everyone was in everyone else's business
☐ no privacy ☐ boundaries not respected ☐ Comfortably close family ☐ loving
☐ shared many positive experiences ☐ supportive ☐ distant, everyone did their own thing
☐ not much time spent together ☐ not a lot of support ☐ angry, lots of fighting/hostility
☐ verbal abuse and conflicts ☐ violence ☐ frightening ☐ scared to make mistakes
☐ other descriptors:

Have any biological relatives ever had any emotional problems or substance abuse? ☐ yes ☐ no
If yes, please explain:

Has any one in your family ever attempted or committed suicide? ☐ yes ☐ no

If yes, please explain:_____

_____

RACE/ETHNICITY

	Self	Spouse
European-American	_____	_____
African-American	_____	_____
Hispanic-American	_____	_____
Native-American	_____	_____
Asian-American	_____	_____
Other _____	_____	_____

RELIGIOUS AFFILIATION

	Self	Spouse
Catholic	_____	_____
Jewish	_____	_____
Muslim	_____	_____
Protestant	_____	_____
Non-Denominational	_____	_____
Eastern (e.g., Hindu, Buddhist)	_____	_____
Other _____	_____	_____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name: _____ Relationship _____

Address:_____
(Street, Apt #) (City) (State) (Zip Code)

Telephone # _____

HEALTH/MEDICAL INFORMATION:

Physician Address & Telephone # Approx Date of last visit

_____

Please list significant medical problems/conditions, and indicate if you are receiving treatment for them:_____

_____

_____

Do any of these problems affect your everyday life? □ yes □ no If yes, how so?_____

_____

_____

Briefly describe any surgeries or hospitalizations for serious illness or injuries (What, where, when, etc.):_____

_____

_____

Have you ever had a serious head injury? □ yes □ no If so, describe:_____

_____

Are you allergic to any medications? □ yes □ no If yes, which one(s):_____

List all medications that you currently use:_____

_____

Dosage (amount and times per day) _____

Reason(s)_____

_____

Please list any "alternative" therapies/treatments you are currently using and the reason for each:_____

_____

_____

Have you ever had or do you now have a problem with any of the following? **Please make a check mark on any line to indicate a problem that you have EVER had, and circle it as well, if you are CURRENTLY experiencing it.**

General

_____ Recent Fever/Chills
_____ Chronic Fatigue
_____ Frequent or Terrifying Nightmares
_____ Night Sweats
_____ Insomnia or Sleep Problems
_____ Chronic Pain
_____ Diabetes
_____ Cancer
_____ Drug Reaction
_____ Emotional Problems
_____ Allergies
_____ Exposure to Trauma (Type:_____)
_____ Cigarette Smoking
_____ Other Tobacco Use
_____ Alcohol Use
_____ Drug Use
_____ Suicide Attempt(s)

Gastrointestinal/Hepatic/Endocrine

_____ Nausea
_____ Gastritis
_____ Ulcers
_____ Vomiting Blood
_____ Pancreatitis
_____ Gallbladder/Stones
_____ Jaundice
_____ Hepatitis
_____ Constipation
_____ Diarrhea
_____ Colitis
_____ Rectal Bleeding
_____ Hemorrhoids
_____ Liver Problems
_____ Weight Loss/Gain
_____ Change in Appetite
_____ Anemia
_____ Thyroid Problems
_____ Always Thirsty
_____ Swollen Glands
_____ Low Blood Sugar

Musculoskeletal

_____ Broken Bones
_____ Bad Back
_____ Herniated Disk
_____ Muscle Weakness
_____ Joint Pain
_____ Arthritis
_____ Gout

Cardiovascular

_____ Angina
_____ Fainting
_____ Lightheadedness
_____ Irregular Heart Beat
_____ High/Low Blood Pressure
_____ Rheumatic Fever
_____ Heart Valve Problems

Pulmonary

_____ Chest Pains/Pressure
_____ Shortness of Breath
_____ Cough
_____ Wheezing/Asthma
_____ Coughing Blood
_____ Tuberculosis
_____ Pneumonia

Neurological

_____ Headaches
_____ Migraines
_____ Skull Fracture
_____ Epilepsy
_____ Stroke
_____ Paralysis
_____ History of Head Injury
_____ Double Vision
_____ Memory Loss
_____ Unsteady Gait

Urinary/Genital

_____ Frequent Urination
_____ Burning on Urination
_____ Weak Urinary System
_____ Incontinence
_____ Urinary Tract Infection
_____ Blood in Urine
_____ Kidney Infection
_____ Penis/Vaginal Discharge
_____ Menstrual Difficulties
_____ Sexual Difficulties
_____ STD

Skin/Sensory Systems

_____ Sores/Abscesses
_____ Skin Rash
_____ Eye Trouble
_____ Hearing Loss
_____ Ringing in Ears
_____ Perforated Septum
_____ Nose Bleeds
_____ Gum Bleeding
_____ Mouth Sores
_____ Difficulty Swallowing