Dr. Samantha DeCaro, Psy.D.
Licensed Clinical Psychologist

(717) 615-2388
DrSamanthaDeCaro@gmail.com
WEBSITE: Drsamdecaro.com

Client History Form

Name: _____ Date: _____

Parent's Name (if client is a child):_____

Social Security Number: _____ DOB: _____

Occupation: _____

Employer: _____

Current School of Child: _____

Who currently lives with you?

_____ Age: _____ Relationship: _____

_____ Age: _____ Relationship: _____

_____ Age: _____ Relationship: _____

_____ Age: _____ Relationship: _____

_____ Age: _____ Relationship: _____

Emergency Contact: _____ **Phone**: _____

Please fill in the blanks:

I decided to purse psychological services NOW because:

_____

_____

_____

Let's pretend a year from now that therapy WORKED. How would your life be different from the way it is right now?

_____

_____

_____

Mental Health

Have you been through therapy before? **Y or N**

If so, most recent therapist?: _____

Was it helpful? **Y or N**

Why?:

_____

_____

Please list all current psychological complaints:

_____

_____

_____

Have you ever tried to hurt yourself in any way? **Y or N**

Please elaborate:

_____

_____

Have you ever thought about ending your life? **Y or N**

Have you ever tried to end your life? **Y or N**

How many times? _____

How did you try to do this? _____

Are you feeling like you might kill yourself today? ***Y or N**

***If your answer is yes, and you are filling this out at home, please contact 911 IMMEDIATELY. Tell them what you are experiencing and WHERE YOU ARE LOCATED**

Are you currently having trouble with aggressive or angry thoughts or feelings? **Y or N**

Please elaborate:

_____

_____

PHYSICAL HEALTH

Primary Care Physician: _____ Last Exam Date: _____

What were the results of last exam?: _____

List any current physical complaints:

_____

_____

_____

List any current diseases or medical conditions:

_____

_____

Head Injuries, Surgeries, or Accidents?

_____

You live with someone that has a medical problem? **Y or N**

Briefly explain:

_____

_____

Sexually active? **Y or N**

Check all that apply to your sexual life: ____N/A

____ Uses condoms	____ Tested regularly for STD's
____ Uses birth control	____ Previously/currently pregnant
____ Has/had an STD	____ Had an abortion
____ Had a miscarriage	____ Thinking about an abortion
____ Sexually satisfied	____ Sexually unsatisfied

Check all that apply:

____ Exercise Regularly	____ Underweight	____Normal Weight
____ Little/No Eating	____ Belief that I am "overweight"	____Sleeping Well
____ Eats Well	____ Belief that I overeat	____ Binge/Purge

Medication and Drug History

List any medication you are currently takes (please include prescribed AND over-the-counter medication):

_____

_____

_____

List ALL drugs/alcohol the you are currently using OR have used at some point in life:

1. _____ How much/often? _____ Last used: _____
2. _____ How much/often? _____ Last used: _____
3. _____ How much/often? _____ Last used: _____
4. _____ How much/often? _____ Last used: _____

Does anyone in the house use drugs now or previously? **Y or N**

If yes, please elaborate:

_____

_____

_____

Family History

List family members in your home GROWING UP:

_____ Age: _____ Relationship: _____

_____ Age: _____ Relationship: _____

_____ Age: _____ Relationship: _____

_____ Age: _____ Relationship: _____

_____ Age: _____ Relationship: _____

Religion in the house? _____

Anything you'd like to share about growing up with this family?

_____

_____

Were you adopted? **Y or N**

Have you lived with a foster family? **Y or N** If yes, when? _____

Relationship History

Currently in a relationship? **Y or N**

With whom? _____ For how long? _____

Please briefly describe the relationship:

_____

_____

Do you have children? **Y or N**

With whom?:_____

Names/Ages of Children:

_____ _____

_____ _____

Please list previous relationships:

1. _____ length of relationship: _____
2. _____ length of relationship: _____
3. _____ length of relationship: _____
4. _____ length of relationship: _____

Please circle your sexual orientation:

Straight Lesbian Gay Bisexual Queer Questioning Other:_____

_____

Please circle your gender identity:

Male Female Trans woman Trans man Non-binary Other: _____

Pronouns:_____

In general, do you feel satisfied in your relationships? **Y or N**

What would you like to see change/improve?

_____

_____

Educational History

PLEASE CIRCLE

Current Grade Level	**OR**	**Highest Level Completed**	
Preschool Kindergarten		GED	High School
1st 2nd 3rd 4th 5th 6th		Vocational	BA/BS
7th 8th 9th 10th 11th 12th		Masters	Doctorate
		Other_____	

If client is a child, please list all previous schools:

1. _____ Dates attended: _____
2. _____ Dates attended: _____
3. _____ Dates attended: _____

If student has switched schools, please list reasons:

_____

Please check all that apply to the child:

What are the child's grades?

_____Mostly A's

_____Mostly B's

_____Mostly C's

_____Mostly D's

_____Failing

_____Other _____

Child's behavior in school?

____Calm/Quiet

____Inattentive/Hyperactive

____Frequent Outbursts

____Oppositional/Defiant

____Nervous/Anxious

____Other _____

List child's strengths in the school setting:

_____

_____

List child's difficulties in school:

_____

_____

What does the child like about school?

_____

_____

What does the child dislike about school?

_____

_____

ADDITIONAL INFORMATION:

If child is under 12, do they engage in pretend play? **Y or N**

Does the child make friends easily? **Y or N**

How would you describe child's social interactions?:

_____

_____

_____

_____

Occupational History

Please list previous places of employment:

____ N/A if client is a child

1. _____ Position: _____ Dates: _____

Reason you left: _____

2. _____ Position: _____ Dates: _____

Reason you left: _____

3. _____ Position: _____ Dates: _____

Reason you left: _____

4. _____ Position: _____ Dates: _____

Reason you left: _____

Did you feel satisfied with any of these jobs? **Y or N**

If yes, which one(s) and why?

_____

_____

If no, which one(s) and why?

_____

_____

Military History

Are you now or have you ever been in the military? **Y** **N**

If you circled yes, please answer the following:

Branch of service: _____

Date of enlistment: _____ Date of discharge: _____

Type of discharge:

___ Honorable ___General ___Other Than Honorable

___ BCD ___ Dishonorable ___ ELS

Military Occupational Specialty: _____

Rank: _____

Problems in service: _____

Service connected injuries/disabilities: _____

Is/Was your spouse also in the military: **Y** **N**

Legal History

Please check what you have experienced / are experiencing:

____ Arrested ____ Holding facility ____Misdemeanor ____ Jail/Prison

____ Probation ____ Residential facility ____Parole ____ Felony conviction

____ DUI ____ Bench Warrant ____Truancy ____CPS involvement

Please elaborate: _____

_____

Social Information

What do you do for fun?

_____

_____

What do you do when you have time off?

_____

_____

Name 3 activities the client would like to do more often:

1._____

2._____

3._____