Amy Robbins, Psy.D.

30 N. Michigan Ave., Suite 1528
Chicago, IL 60602
312-404-2237

Preliminary Information Forms

A. Identifying Information

Name: _____ Date: _____

Birth date: _____ Age: _____ Social Security #_____

Address: _____
(Street) (City) (State) (Zip Code)

Gender: _____ Male _____ Female

Relationship Status: _____ Committed Relationship ____ Single ____ Married

____Separated/Divorced ____Domestic Partnership _____Widowed

Ethnic/Racial Identity: ____African American ____Asian American (please specify): _____

____ Caucasian ____Biracial (please specify): _____

____Latina/Latino ____ Native American

____ Other

To (re) schedule an appointment, where may I contact you?

____ Home phone: _____ _____Cell/Work: _____

May I leave a message on the answering machine? ____ Yes ____No (Please check one)

May I leave a message with someone at this number? ____ Yes _____No (Please check one)

Who may I contact in case of an emergency?

Name: _____ Phone: _____

Address: _____
(Street) (City) (State) (Zip Code)

Relationship to you: _____

Did someone refer you?

_____ Yes If "yes", who? _____

_____ No

B. Clinical Information

Have you ever had previous counseling or psychotherapy? _____ Yes _____No

If "yes," by whom, when, and for what? _____

Have you ever been psychiatrically hospitalized? ____ Yes _____ No

Have you ever made a suicide attempt/gesture? _____ Yes _____ No

Please list current or chronic health problems:

_____

Please list current medications (prescribed & OTC):

_____

In the space below, please briefly describe your reason(s) for seeking services:

PLEASE USE THE SCALE BELOW TO INDICATE YOUR CURRENT LEVEL OF DISTRESS ON THE FOLLOWING ITEMS:

	No concern	Minimal		Moderate		Urgent
Academic/Occupational concerns	0	1	2	3	4	5
Perfectionism	0	1	2	3	4	5
Financial Concerns	0	1	2	3	4	5
Relationship with family or friends	0	1	2	3	4	5
Relationship with romantic partner	0	1	2	3	4	5
Sexual orientation concerns	0	1	2	3	4	5
Racial/cultural issues or conflict	0	1	2	3	4	5

Recent loss or death	0	1	2	3	4	5
Loneliness	0	1	2	3	4	5
Low self-esteem, self-confidence	0	1	2	3	4	5
Depression	0	1	2	3	4	5
Anxiety, fears, worries	0	1	2	3	4	5
Irritability, anger	0	1	2	3	4	5
Sleep problems	0	1	2	3	4	5
Eating problems	0	1	2	3	4	5
Body image concerns	0	1	2	3	4	5
Sexual concerns	0	1	2	3	4	5
Concerns regarding sexually transmitted diseases	0	1	2	3	4	5
Survivor of abuse (Emotional, physical or sexual)	0	1	2	3	4	5
Post-partum concerns	0	1	2	3	4	5
Problems with alcohol or drugs	0	1	2	3	4	5
Other addictive concerns	0	1	2	3	4	5
Cutting/Self-injurious behavior	0	1	2	3	4	5
Suicidal thoughts/behaviors	0	1	2	3	4	5
Fear of endangering others	0	1	2	3	4	5

Please indicate how often you use the following substances

	DAILY	WEEKLY	MONTHLY	RARELY	NEVER
Alcohol					
Nicotine					
Marijuana					
Ecstasy or other hallucinogens					
Cocaine and/or other stimulants					
Opioids (heroin, morphine)					
Sedatives, hypnotics, tranquilizers					

Thank you for completing the paperwork. Data is solely used for the purpose of understanding treatment concerns and will be held strictly confidential.