

GOODMAN AND HEIDRICH PSYCHOLOGICAL EVALUATIONS INC.

Psychological Evaluations Center and Psychotherapy

270 26th Street #201
Santa Monica, CA 90402

818-917-4524
310-748-8393

Dgoodman@ucla.edu
Heidrich.Brenda@gmail.com

Lic: Psy 22613
Lic: Psy 29105

Client Information Sheet

Client's name: _____ Date: _____

Address: _____

City, State: _____ Zip: _____

Phone numbers *with area code* Home: () _____

Work: () _____ Cell: () _____

Birth date: _____ Age: _____ Social Security Number: _____

Employer: _____

Position: _____ For how long? _____

Education: _____

Marital/relationship status: _____ Significant other's name: _____

Significant other's age and sex: _____ How long together? _____

Total number of children: _____

How did you hear about Goodman and Heidrich

Psychological Evaluations Inc.? _____

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Who shall we contact in case of emergency?

Name: _____ Phone () _____

In this box, please indicate the address and telephone number you want us to use to when we need to contact you. If this box is left blank, we will use the address and any of the telephone numbers you have provided above. _____

If you do *not* want us to leave a message on your answering machine, please tell us how you want us to reach you by phone: _____

I hereby consent for Goodman and Heidrich Psychological Evaluations Inc. to provide evaluation and treatment to me.

Signature

Date

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Medical and Health History

Name: _____ Date: _____

List any allergies you have: _____ None _____

Primary Care Physician: _____ Address: _____

City: _____ State: _____ ZIP: _____

Primary Care Physician's phone number: (____) _____

Date of your most recent physical examination: _____

Please list all current medications and dosages:

Name of Medication	Dosage	Name of Prescribing Doctor	When did you start taking it?

Please list all current or past health problems, and any major operations:

Current	Past

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List all therapists you have seen, and dates you saw them: _____

List any substance abuse treatment or inpatient psychiatric treatment you have had, and the dates: _____

Please indicate which of these substances you currently use:

Substance	Amount used	How often?
Cigarettes		
Alcohol		
Pills not prescribed for me		
Marijuana		
Cocaine or crack		
LSD		
Heroin		
Other (please list):		

What kind of problem brings you to Goodman and Heidrich Psychological Evaluations Inc?

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Type of Incident

Auto Dog Bite Fall

Other _____

When did Incident Occur? _____

Pain on scale 1-10 episodic _____

Pain on scale 1-10 constant _____

Medication being taken for incident pain _____

Body parts affected by incident _____

Type of procedure expected

SCS (spinal cord stimulator) Implant SCS (spinal cord stimulator) Trial

Gastric Bypass. Post-Accident-Incident Evaluation

Peripheral Nerve Stimulator. None

Other _____

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Please indicate if you are having any of the following problems, or if you had them in the past:

	I have this now	I had it in the past
<u>Difficulty falling asleep or staying asleep</u>	_____	_____
<u>Sleeping too much</u>	_____	_____
<u>Change in appetite, weight loss, or weight gain</u>	_____	_____
<u>Frequent crying</u>	_____	_____
<u>Panic attacks or anxiety attacks</u>	_____	_____
<u>Thoughts of killing or hurting myself</u>	_____	_____
<u>Attempts to kill or hurt myself</u>	_____	_____
<u>Problems concentrating</u>	_____	_____
<u>Problems remembering things</u>	_____	_____
<u>Periods of daily sadness lasting more than two weeks</u>	_____	_____
<u>I startle easily</u>	_____	_____
<u>Can't stop remembering upsetting past events</u>	_____	_____
<u>Difficulty controlling my temper</u>	_____	_____
<u>I physically hurt other people</u>	_____	_____
<u>I break things sometimes</u>	_____	_____
<u>I worry a lot</u>	_____	_____
<u>Little or no interest in sex</u>	_____	_____
<u>I feel tired almost every day</u>	_____	_____
<u>Feelings of unreality</u>	_____	_____
<u>Made myself throw up in order to lose weight</u>	_____	_____
<u>Used laxatives or exercised excessively to lose weight</u>	_____	_____
<u>I often feel like I am an outsider</u>	_____	_____
<u>Sexual problems</u>	_____	_____
<u>Worry that something is wrong with my body</u>	_____	_____
<u>Frequent arguments with the people I live with</u>	_____	_____
<u>I hear voices inside my head</u>	_____	_____
<u>Other (please list): _____</u>	_____	_____

Signature _____