Shelly Royalty, Psy.D., M.Div. **760-688-0110**
325 Carlsbad Village Dr. Suite F2, Carlsbad, CA 92008

Patient Information

Name: _____ Date of Birth: _____

Social Security Number: _____ Male/Female (circle) M F

Address: _____

City: _____ State: _____ Zip: _____

May I send mail to you at this address? (circle) Yes No

Home Number: _____ Mobile: _____ Work: _____

Which number may I use to contact you and/or leave a message? _____

_____

Marital Status: _____ Date of Present Marriage: _____

Name of Spouse: _____ Date of Birth: _____

Names and ages of children: _____

List persons living in your home: _____

_____

Occupation: _____ Employer: _____

How long in this occupation? _____ How long with this employer? _____

Education: (List highest level of education attained): _____

Church Affiliation (if applicable): _____

Who Referred You: _____ May I thank them for referring you? (circle) Yes No

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Person to notify in case of an emergency:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Relationship to You: _____

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Patient Health History

Patient Name:_____

Person completing the form (if other than patient):_____

Name of Guardian (If applicable):_____

Primary Care Physician:_____Date of Last Exam:_____

Current Medical Condition(s):_____

Any perinatal or developmental abnormalities? No Yes (If yes, please explain on back of form)

Are you currently taking any prescription or "over the counter" medication(s)? No Yes

If yes, please identify the name, current dosage, and date began for each:_____

_____

Do you have any allergies: No Yes If yes, please list:_____

Have you received any Psychological/Psychiatric treatment before? No Yes

If yes, please show the total number of outpatient visits you have had: _____

What was your age at the first visit?_____

Have you had any inpatient/hospital treatment for mental health or substance abuse? No Yes

If yes, please list facility(ies) date(s) and length(s) of stay(s):_____

_____

Do you smoke cigarettes? No Yes If yes, how many per day?:_____

How much alcohol do you drink per week on average? Drinks per week:_____

Have you had problems with your drinking (legal, health, work, relationship)?_____

What caused you to get help now?_____

_____

Please indicate if you are experiencing any of the following symptoms:

Yes / No - Suicidal Thoughts/Impulses
Yes / No - Homicidal Thoughts/Impulses
Yes / No - Appetite Problems
Yes / No - Sleep Problems
Yes / No - Physical Complaints
Yes / No - Anger/Irritability
Yes / No - Isolation/Social Withdrawal
Yes / No - Anxiety/Panic
Yes / No - Phobia
Yes / No - Bingeing/Purging
Yes / No - Poor Impulse Control
Yes / No - Violence Toward Others
Yes / No - Destruction of Property
Yes / No - Strange or Unusual Behavior
Yes / No - Confused or Irrational Thinking
Yes / No - Bothersome Repetitive Thoughts or Behaviors
Yes / No - Self-mutilation

Signed Patient/Guardian: _____ *Date:*_____