Patricia D. Post, Ph.D.
Jodie Guth, Ph.D.
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Clarke McLaughlin, L.P.C., L.M.F.T., L.A.C.
Alice P.Williams, L.P.C., L.M.F.T.
Brenda Hollenbeck, L.P.C., L.M.F.T.
Brenda LaFleur, L.C.S.W.

Dear New Patient:

Enclosed you will find two (2) packets to be filled out prior to your appointment at the Psychology Clinic. One packet is your general information for office use. The other packet is a questionnaire from Dr. Jodie Guth used only by her. Please complete each packet and bring them to your scheduled appointment.

If you have any questions please feel free to call us: 337-474-2682

Thank you,

The Psychology Clinic

PERSONAL HISTORY QUESTIONNAIRE

Date Completed: _____ Referred By: _____

The following information will be helpful in completing your evaluation. Please bring this completed form to your first visit with Dr. Jodie Guth. You will have the opportunity to explain or clarify things that may be difficult to state in writing. Please provide as much of the requested information as possible. Use the back of these pages as needed. This form will become part of your file at The Psychology Clinic and will not be reviewed by anyone other than Dr. Guth without your written permission.

NAME: _____ GENDER: M F AGE: _____ DOB: _____

Please list all physicians who are currently providing treatment to you:

Physician's Name:	Physician's Specialty:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list all of your current medications: (use back of page if necessary)

Medication	Dosage	Prescribed by:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check the main reason(s) that you are meeting with Dr. Guth:

_____ Psychological evaluation before surgery
_____ Help coping with pain and/or disability
_____ Anxiety Management
_____ Depression
_____ Sexual issues
_____ Other (please describe) _____

ILLNESS/ACCIDENT HISTORY

Please describe any illness or disability that you may currently be experiencing.
Date that illness/injury began: _____

If the injury/illness is due to an accident, please describe the accident in detail. Start with the events just before the accident and tell what happened immediately afterward. (Use the back of this page if needed.)_____
_____
_____
_____
_____
_____
_____
_____

List all treatments/surgeries for this illness/injury and indicate whether treatment was helpful.
(use back of page if necessary)

Treatment/Surgery	Date of Treatment/Surgery	Doctor	Helpful
_____			Y or N
_____			Y or N
_____			Y or N
_____			Y or N
_____			Y or N

Do you expect to have further treatment or surgeries? ……..…… Y or N
If yes, please explain: _____

How does this condition affect your daily life now? _____
_____
_____
_____

Does your condition keep you from doing things you would like to do?…… Y or N

Describe a typical day in your life BEFORE the illness/accident: _____
_____
_____
_____

What was your work schedule BEFORE the illness/accident? _____
_____

What kind of work did you do? _____

What were your job duties? _____
_____

How did you spend your family time BEFORE the illness/accident? _____
_____
_____

What kind of recreational activities of hobbies did you participate in BEFORE the illness/accident? _____
_____
_____

SINCE the accident/illness, what has a typical day been like for you? _____
_____
_____

SINCE the accident/illness, what is your work schedule and work activities like? _____
_____
_____

SINCE the accident/illness, how do you spend family time? _____
_____
_____

SINCE the accident/illness, what are your interests/hobbies? _____
_____
_____

OTHER MEDICAL HISTORY

What other medical conditions do you have?

_____
_____
_____

List all other surgeries you have had:

_____
_____
_____

PERSONAL INFORMATION

Current Height: _____ Current Weight: _____

Have you recently lost weight? (more than 5 pounds) …….. Y or N

Have you recently gained weight? (more than 5 pounds) ……. Y or N

Are you having trouble falling asleep or staying asleep? …….. Y or N
How many hours of sleep do you average per night? _____

Has your interest in sex changed recently? …… Y or N

Do you experience crying spells? …….. Y or N

Are you having any thoughts of suicide? ……... Y or N

Have you ever intentionally tried to harm yourself in any way? …….Y or N

Have any family members ever attempted suicide? …… Y or N

Have you ever had outpatient mental health treatments? ……. Y or N

Have you ever been hospitalized for psychological reasons? ……. Y or N
If yes, provide date and effectiveness of treatment. _____

Do you experience problems with: uncontrollable worry? ……...Y or N
sudden unexplained anxiety? …….. .Y or N
repetitive behavior or thoughts that are difficult to control? ….. .Y or N

Do you drink alcoholic beverages? ……. Y or N
If yes, estimate your number of drinks per week. _____

Have you ever received a DWI? ……..… Y or N

Have you ever had treatment for substance abuse? ……..… Y or N

Have you ever tried illegal drugs? ……..….. Y or N
If yes, when? _____

Do you smoke cigarettes? ……..Y or N
If yes, how much? _____

EDUCATIONAL HISTORY

Did you experience learning difficulties in school? ……..…Y or N

Did you ever repeat a grade? ……..…….. Y or N

Were you ever suspended or expelled for behavior problems? ……..….. Y or N

Did you graduate from high school? ……..…..……. Y or N
If yes, what year? _____ What school? _____
If no, what was the highest grade that you completed? _____ Did you earn a GED? …...Y or N
List all college degrees or technical training:
_____
_____

FAMILY HISTORY

Where were you born? _____ Where were you raised? _____
Who raised you? _____

Describe your Mom:
Age: _____ Occupation: _____ Health Status: _____
Personality Characteristics: _____

Describe your Dad:

Age: _____ Occupation: _____ Health Status: _____

Personality Characteristics: _____

How many brothers do you have? _____ How many sisters do you have? _____

Ages: _____, _____, _____, _____ Ages: _____, _____, _____, _____

How was discipline handled in your home? _____

_____

_____

In your opinion, have you ever experienced: physical abuse? ……..……Y or N

sexual abuse? ……Y or N

emotional abuse? ……..Y or N

How was religion handled in your upbringing?

____ No Religion ____Not very important ____Somewhat important ____Very important

What is the role of religion in your life today?

____No Religion ____Not very important ____Somewhat important ____Very important

OCCUPATIONAL HISTORY

Please list all full time and part-time jobs starting with the most recent. (Use back of page if needed)

Employer Job Title Years of Employment

_____

_____

_____

_____

_____

_____

_____

_____

MARITAL HISTORY

Please list all marriages and the duration of each.

Spouse Years Married

_____

_____

_____

_____

Please list your children's names and ages:

Names Ages

_____

_____

_____

_____

LEGAL HISTORY

Have you ever been arrested or charged with a crime? ……. Y or N
If yes, please explain? _____

MILITARY HISTORY

Have you ever served in the US Military? …… Y or N
If yes, what branch? _____
Dates of service: _____
Rank at discharge: _____
Was the discharge honorable? _____

THANK YOU FOR COMPLETING THIS FORM!

Please feel free to make notes of questions that you would like to discuss with Dr. Guth

_____
_____
_____
_____
_____
_____
_____
_____