Jenifer Hoover, Psy.D.
Clinical Psychologist license # 19236
2500 Central Avenue, Suite 206 Alameda, CA 94501
(415) 867-8936
drhoover@drjenhoover.com

Client Information

Please complete, print and bring to your first session

This form represents protected, confidential health information

Full name: Today's Date:

Street: City: State: Zip:

Phone: May I leave a message? ☐ Yes ☐ No

Alternative Phone: May I leave a message? ☐ Yes ☐ No

*E-mail address:

*Email correspondence is ***not*** considered to be a confidential medium of communication.

Emergency contact name: Phone: Relationship:

Birth date: Place of Birth: Age:

Sex: Preferred gender identification:

Ethnicity:

Relationship Status:

Education:

Occupation / Employer: How long?

Do you enjoy your work? ☐ Yes ☐ No ☐ Sometimes

Do you have children? ☐ Yes ☐ No Ages? Living with you?

Do you care for other family members?

Do you consider yourself to be spiritual or religious? ☐ Yes ☐ No

If yes, please describe your faith and/or religious or spiritual affiliation(s):

Referred by (if applicable):

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Presenting Issues

Why are you seeking services?

What significant life changes or stressful events have you experienced recently?

What do you consider to be some of your strengths?

What would you most like to accomplish in your therapy?

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
☐ Yes ☐ No If yes, please briefly describe the nature of those services

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PSYCHOLOGICAL SYMPTOMS CHECKLIST

Please check the appropriate box that represents the degree to which you have experienced or have been troubled by the following thoughts, feelings, and behaviors during the past month.

Thoughts

I experience difficulty concentrating
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Frequently

I experience blaming or negative thoughts about myself
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Frequently

I experience blaming or negative thoughts about others
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Frequently

I experience catastrophic thinking (fantasizing about terrible or the worst possible outcomes)
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Frequently

I experience worrying thoughts
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Frequently

I have problems with memory or word/name recall
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Frequently

I experience racing thoughts
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Frequently

I repeatedly think and rethink about the same situation
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Frequently

I have nightmares
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Frequently

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PSYCHOLOGICAL SYMPTOMS CHECKLIST (Continued)

Please check the appropriate box that represents the degree to which you have experienced or have been troubled by the following thoughts, feelings, and behaviors during the past month.

Emotions

I am afraid of specific places or circumstances
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Frequently

I feel anxious
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Frequently

I feel sad or blue
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Frequently

I feel lonely
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Frequently

I feel irritable and/or angry
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Frequently

I feel bored and/or unengaged
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Frequently

I feel guilty
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Frequently

I feel hopeless about the future
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Frequently

I feel unloved or unappreciated
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Frequently

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PSYCHOLOGICAL SYMPTOMS CHECKLIST (Continued)

Please check the appropriate box that represents the degree to which you have experienced or have been troubled by the following thoughts, feelings, and behaviors during the past month.

Behaviors

I feel restless
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Frequently

I use tobacco (in any form)
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Frequently

I use prescription or other drugs to change my mood
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Frequently

I drink alcoholic beverages
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Frequently

I find myself excessively talking
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Frequently

I cry
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Frequently

I experience sleeping problems (too much or too little)
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Frequently

I experience eating problems (too much or too little)
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Frequently

I have trouble communicating
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Frequently

I avoid responsibilities
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Frequently

I experience compulsive behaviors
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Frequently

I find myself verbally or physically acting out
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Frequently

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Physical Health

Primary Care Physician:

Phone:

Date of your most recent physical examination:

How would you rate your current physical health?

☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Very good

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

Are you currently experiencing any chronic pain? ☐Yes ☐No If yes, please describe:

Please list any prescription medications you're taking (if any):

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FAMILY MENTAL HEALTH HISTORY

In the section below identify any family history of the indicated issue. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

ADHD
☐ Yes ☐ No If yes, which family member?

Alcohol/Substance Abuse
☐ Yes ☐ No If yes, which family member?

Anxiety Disorder
☐ Yes ☐ No If yes, which family member?

Depression
☐ Yes ☐ No If yes, which family member?

Bipolar Disorder
☐ Yes ☐ No If yes, which family member?

Domestic Violence
☐ Yes ☐ No If yes, which family member?

Eating Disorders
☐ Yes ☐ No If yes, which family member?

Obsessive Compulsive Behavior
☐ Yes ☐ No If yes, which family member?

Phobias/Panic
☐ Yes ☐ No If yes, which family member?

Schizophrenia
☐ Yes ☐ No If yes, which family member?

Suicide Attempts:
☐ Yes ☐ No If yes, which family member?