**Gillian Bush, Psy.D.**

*2700 PGA Blvd, Suite 101*

*Palm Beach Gardens, Florida 33410*

*(561) 596-4429 Fax: (561) 622-8040*

**Patient Record Sheet**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Who referred you?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Phone Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it ok to leave you a message on this number? (circle) Yes No

**Cell Phone Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it ok to leave you a message on this number? (circle) Yes No

Which number is best to reach you? (circle) Home Cell Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital Status**: (circle) Single Married Widowed Coupled If Married/Coupled, for how long? \_\_\_\_\_\_\_

**Do you have any children**? (circle) Yes No

If Yes, please list first name and ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Local Emergency Contact**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Numbers: Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In order to limit costs and therefore charges, Dr. Bush must operate on a cash, check, or credit card basis. **Payment for services is expected at the time the services are rendered.** Dr. Bush does not participate in any insurance plans.

**PATIENT QUESTIONNAIRE**

**What has brought you here today?**

**How long has this been going on for?**

**Have you sought treatment for this before?** If yes, list where/with whom and dates of treatment.

**What would you like to accomplish through therapy? What are your goals?**

**Do you anticipate any potential obstacles to your therapy at this point in time? If yes, what are they?**

**On a scale from 1 to 10, how motivated are you to seek therapy at this time?** (circle)

**1 --------- 2 --------- 3 --------- 4 --------- 5 --------- 6 --------- 7 --------- 8 --------- 9 --------- 10**

**(not at all motivated) (moderately) (very motivated)**

**Family History:**

Has anyone in your family suffered with depression? (Circle) Yes No If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has anyone in your family suffered with anxiety? (Circle) Yes No If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has anyone in your family suffered with schizophrenia? (Circle) Yes No If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has anyone in your family suffered with an eating disorder? (Circle) Yes No If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has anyone in your family suffered with substance abuse? (Circle) Yes No If yes, who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has anyone in your family suffered with chronic pain? (Circle) Yes No If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently taking any psychiatric medications?** If yes, please list medications and the name/phone number of your prescriber.

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**Do you have a nutritionist?** If yes, please list name/ phone number. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Habits:**

Do you smoke tobacco? (circle) Yes No If yes, how much per day?\_\_\_\_\_\_\_\_\_\_ For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? (circle) Yes No If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_ How many drinks?\_\_\_\_\_\_\_\_\_\_

Do you drink caffeine? (circle) Yes No If yes, how much per day?\_\_\_\_\_\_\_\_\_\_ For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently or have you, in the past, used recreational drugs? (circle) Yes No

If yes, what drug(s)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How much did you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is there anything else that you think I should know about you?**