Dr. Laura Thomson
Psychologists & Associates

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Date:
Name [First]:
[Last]:
Date of Birth:
Age:
Occupation:

Referred By:
Address:
Home Phone:
Work Phone:
Cell Phone:
E-mail:

Partner's Name [First]:
[Last]:
Address:
Home Phone:

Work Phone:
Cell Phone:
E-mail:
Occupation:

Email address for appointment reminders:

PHYSICAL HEALTH INFORMATION:

Family physician:
Phone number:

Psychiatrist:

Please list any significant medical problems that you have had (and when):

PLEASE LIST ALL MEDICATIONS THAT YOU CURRENTLY TAKE:

MEDICATION	WHAT FOR?	DOSAGE

Please list any mental health medications (antidepressant, anti-anxiety, mood stabilizer, ADHD medications) that you have taken in the past but no longer take:

Please list any allergies:

Please specify any previous mental health diagnoses:

HAVE ANY OF YOUR BIOLOGICAL RELATIVES ON EITHER SIDE OF THE FAMILY HAD ANY OF THE FOLLOWING:

Condition or Event	Relationship to Yourself
Anxiety	
Panic Attacks	
Depression	
Obsessive-compulsive disorder	
Bipolar disorder	
Death from suicide	
Alcohol or drug problems	
Police record (arrests, jail)	
Schizophrenia	
Developmental delays	
Autism/ Asperger's	
Learning disorder	
Attention problems (ADHD)	
Tourette's or other tic problems	
Other (please describe)	

If separated, is litigation pending?

◯ YES ◯ NO

If yes, describe:

What is the custody arrangement and visitation schedule for the children:

CHILDREN:

NAME	AGE

STEP CHILDREN:

NAME	AGE

GENERAL REVIEW:

What are your strengths:

What are your top three concerns:

1)

2)

3)

Have you ever had direct contact with any social agency, psychologist, clinic or private agency?

◯ YES ◯ NO

If yes, please list:

Name of Professional Agency	Date of Service

Do you have extended health benefits that cover the cost of psychological services?

◯ YES ◯ NO

If yes, please give the details of the plan:

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