Spectrus Psychological Services, PLLC

info@spectruspsych.com | www.SpectrusPsych.com

Adult History Form

Name: _____ Age: _____ Date of Birth: _____

Race & Ethnicity: _____ Religion: _____

Sexual Orientation: _____ Gender Identity: _____

Address: _____

Please describe the concerns or problems for which you are seeking services:

_____

_____

How did you hear about us?
☐Friend/Family ☐Google ☐Psychology Today ☐Insurance ☐Other

RELATIONSHIPS

Relationship status: ☐Married ☐Separated ☐Divorced ☐ Single

Individuals with whom the patient lives (include pets):

Name	Relationship	Age

Quality of patient's current relationships, including prominent or recurrent difficulties:

_____

_____

_____

Patient's support network:
☐Family ☐Partner/Spouse ☐Friends ☐Coworkers ☐Professionals

BIRTH & DEVELOPMENT

My Mother's Pregnancy With Me

Planned pregnancy? Y ☐/N ☐ Desired pregnancy? Y ☐/N ☐ Prenatal care received? Y ☐/N ☐
Drug use during pregnancy: Y ☐/N ☐ Alcohol use during pregnancy: Y ☐/N ☐
Adopted: Y ☐/N ☐ If yes, open or closed adoption? _____

My Developmental Milestones

Please describe any developmental **differences, problems, or delays**.

☐Speech ☐Walking/Crawling ☐Social ☐Learning/Academic

Parenting I Received

Please briefly describe relationships with parents and important caregivers:

☐Close ☐Warm ☐Distant ☐Strained ☐Abusive ☐Neglectful

MEDICAL

My Medical History

Please indicate past and present medical conditions:

Head injury Y☐/N☐ _____

Hearing impairment Y☐/N☐ _____

Visual impairment Y☐/N☐ _____

Sensory problems Y☐/N☐ _____

Neurological condition Y☐/N☐ _____

Respiratory problem(s) Y☐/N☐ _____

Heart condition Y☐/N☐ _____

Gastrointestinal condition Y☐/N☐ _____

Autoimmune Disorder(s) Y☐/N☐ _____

Epilepsy or Seizures Y☐/N☐ _____

Other medical conditions (past/present):

_____

_____

Current Medications	Dosage	Condition Treating

ACADEMIC & OCCUPATIONAL

Academic History

Highest completed educational level:

☐High School ☐Vocational ☐Bachelors ☐Masters ☐ Doctorate

☐Repeated Grades ☐Behavior Problems ☐Attention Problems ☐Learning Problems

Patient Occupational History

Current Occupation/Employer:

Position/Roles: Length of Employment:

Previous Occupations/Employers:

Position/Roles: Length of Employment:

Work Problems: ☐Firing ☐Quitting ☐Attendance ☐Performance ☐Relationships

PSYCHIATRIC HISTORY

Family Psychiatric History

Please indicate mental health problems experienced by ***members of your biological family***:

Condition	Maternal/Paternal
Depression Disorders	M ☐/P☐
Suicide Attempt or Suicide Completion	M ☐/P☐
Anxiety Disorders / Panic Attacks	M ☐/P☐
Obsessive Compulsive or Hoarding Disorders	M ☐/P☐
Bipolar Disorder	M ☐/P☐
Schizophrenia or Psychotic Disorders	M ☐/P☐
History of abuse, neglect, or trauma	M ☐/P☐
Posttraumatic Stress Disorder	M ☐/P☐
Attention Deficit Hyperactivity Disorder	M ☐/P☐
Learning Disorders	M ☐/P☐
Autism Spectrum Disorder (including Asperger's)	M ☐/P☐
Alcohol or Drug Abuse	M ☐/P☐
Incarceration or arrests	M ☐/P☐
Personality Disorder	M ☐/P☐
Other:	M ☐/P☐

Patient Psychiatric *HISTORY*

Condition	✓
Depression Disorders	☐
Suicidality / Self - Harming	☐
Anxiety Disorders / Panic Attacks	☐
Obsessive Compulsive or Hoarding Disorders	☐
Bipolar Disorder	☐
Schizophrenia or Psychotic Disorders	☐
History of abuse, neglect, or trauma	☐
Posttraumatic Stress Disorder	☐
Attention Deficit Hyperactivity Disorder	☐
Learning Disorder	☐
Autism Spectrum Disorder (including Aspergers)	☐
Alcohol or Drug Abuse	☐
Incarceration or arrests	☐
Personality Disorder	☐
Other:	☐

Patient *CURRENT* Concerns

Symptom	✓	Symptom	✓
Abandonment Fears	☐	Hearing / Seeing Things	☐
Academic/ Learning Difficulties	☐	Hyperactivity/ Restlessness	☐
Aggression (physical/verbal)	☐	Hypervigilance	☐
Alcohol / Drug Problems	☐	Impulsivity / Risky Behaviors	☐
Anger / Frustration / Irritability	☐	Sleep Problems / Nightmares	☐
Anxiety / Worry/Panic	☐	Loss/ Grief	☐
Attention / Concentration Problems	☐	Lying	☐
Body Image / Eating Problems	☐	Memory difficulties	☐
Communication / Speech Problems	☐	Obsessions / Compulsions	☐
Defiance/Rule Breaking	☐	Odd Beliefs / Delusions	☐
Discrimination/ Minority Stress	☐	Poor hygiene	☐
Depressed mood / Mood Swings	☐	Relationship difficulties	☐
Elevated mood/Mania	☐	Self-Harming / Suicidality	☐
Eye contact (poor/odd/infrequent)	☐	Sensory Sensitivities	☐
Gender identity / Sexual Orientation	☐	Trauma Symptoms	☐

Abuse & Trauma History

Natural disaster	☐	Robbery or home invasion	☐
Fire or explosion	☐	Witnessed trauma or abuse	☐
Car accident	☐	Domestic violence	☐
Physical assault	☐	Childhood physical abuse	☐
Sexual assault	☐	Childhood sexual abuse	☐
Unwanted sexual contact	☐	Childhood verbal abuse	☐
Combat or warzone exposure	☐	Childhood emotional abuse	☐
Other:	☐	Other:	☐

Was abuse or assault reported to police or other authorities: Y☐/N ☐

Mental Health Treatment History

Outpatient and Inpatient Therapy Services

If the patient has ever received therapy services in the past, please provide relevant information below:

_____

Assessment Services

If the patient has ever received an assessment in the past, please provide relevant information below:

_____

Are you able to provide copy of past assessment report(s)? Y☐ / N ☐

Patient Strengths & Weaknesses

_____

_____

_____

Patient Communication Preferences

I agree to receive communication from Spectrus Psychological Services, PLLC via the following methods:
Please provide ONLY the information for preferred methods of contact.

Cell Phone : _____
☐ YES, Spectrus may leave a voicemail at this number.
☐ NO, Spectrus may NOT leave a voicemail at this number.

Home Phone : _____
☐ YES, Spectrus may leave a voicemail at this number.
☐ NO, Spectrus may NOT leave a voicemail at this number.

Work Phone : _____
☐ YES, Spectrus may leave a voicemail at this number.
☐ NO, Spectrus may NOT leave a voicemail at this number.

I would like to receive email ***communication*** at the following email address.
Email : _____

I would like to receive email ***appointment reminders*** at the following email address.
Email : _____

Emergency Contact #1_____
Name Relationship Phone
_____
Street Address City State Zip

Emergency Contact #2_____
Name Relationship Phone
_____
Street Address City State Zip

_____
Patient Name (printed)

_____ _____
Signature Date

_____ _____
Signature of Authorized Representative Date

_____
Relationship to Patient

Insurance & Payment Information

In the event your insurance carrier does not cover the cost of services, the patient or the individual identified as the financially responsible party will be responsible for the full cost of services rendered.

Insurance Plan Information	
Insurance Company:	
Insurance Address:	
Insurance Phone Number:	
Member ID:	Group ID:
Information of the Insured Individual	
Relationship to Patient:	
Employer:	
Address:	
Phone Number:	DOB:

I authorize regularly scheduled charges to my Visa, MasterCard, American Express or Discover card. I Authorize **Jennifer S. Williams, PhD** to charge my card for missed appointment fees, late cancellation fees, the balance of fees denied by my insurance company, or not paid by my insurance company within 90 days of date of service, and insufficient check amounts plus insufficient check fee of $30 per bad check. I authorize these charges to my card beginning _____/_____/_____ to the end of my treatment period. If I have questions about these charges, I agree to contact **Jennifer S. Williams, PhD**. The charges labeled on my credit card will not be my provider's name to preserve confidentiality. I agree that I will not pursue a refund directly through my credit/debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by my provider.

***Initial:*_____**

Please complete the information below:

I _____ authorize **Jennifer S. Williams, PhD** to
Name (as it appears on credit card)
charge my credit card, indicated below, on or after the day in which I receive my therapy session. I understand that I will only receive a **5-day** advance notice of the charge if it exceeds $**150.00**.

Billing Address_____ Phone#_____

City, State, Zip _____ Email _____

Please make sure the following information is accurate.

Account Type: ☐ Visa ☐ MasterCard ☐ Amex ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

_____
Patient Name (printed)

_____ _____
Signature Date

_____ _____
Signature of Authorized Representative Date

_____
Relationship to Patient