Meredith M. Sargent, Ph.D.
Licensed Clinical Psychologist
2950 Northup Way, Suite 204
Bellevue, WA 98004
425.739.4772 (phone) - 425.739.4778 (fax)
msargentphd@gmail.com

Personal Information (Adolescent) – Psychotherapy

Name:_____ Date of Birth: _____ Age:_____
Address: _____(city)_____ (state) _____ (zip) _____
Home phone:_____ Cell: _____ Work: _____
Email address: _____ SS#:_____

Name of School:_____ Grade: _____
If you have a job, please indicate where you work and what you do at your job: _____
_____

Current Relationship Status: _____
Name of Spouse/Partner/Significant Other: _____

Do you have any children? _____ If yes, please identify:
Name: _____ M/F Date of Birth: _____ Age: ____ Grade in School:
Name: _____ M/F Date of Birth: _____ Age: ____ Grade in School:

Primary Physician: _____ Phone: _____
Address: _____ Fax: _____
Date of last physical exam: _____ Email: _____

Referred by: _____ Relationship: _____
Address: _____ Phone: _____
Email: _____

Why are you coming in for treatment at this time? _____
_____
_____
_____
_____

How long have you experienced your current problem(s)? _____

What is the most important goal(s) you want to achieve during these sessions? _____
_____
_____
_____

Please list any major stresses you have experienced in the past five years: _____
_____
_____
_____

Have you had any trouble with the law? _____ If yes, please describe in detail: _____
_____
_____
_____

Do you have a driver's license? _____ If yes, have you received traffic tickets and/or been in car accidents?
_____
_____

Do you have problems with your temper? _____ If yes, please describe in detail: _____
_____
_____

Have you ever lost your temper to the point you hurt someone or damaged property? _____ If yes, please describe in detail: _____
_____
_____
_____

Have you seen a therapist or psychiatrist before? _____ If yes, please provide the following:
When/where in treatment: Type/Length of Treatment: Outcome (i.e. was it helpful?)
_____
_____
_____

Medical History

Have you had any serious or chronic illnesses? _____ If yes, please describe in detail: _____
_____
_____
_____

Have you had any surgeries? _____ If yes, please describe in detail: _____
_____
_____

Do you suffer from allergies? _____ If yes, please describe in detail: _____
_____
_____

Do you have any hearing or vision problems? _____ If yes, please describe in detail: _____
_____
_____

Are you currently taking any medication (prescribed or over-the-counter)? _____ If yes, please provide the following information:

Medication Dose Frequency Prescribing Doctor

_____
_____
_____
_____
_____
_____

How much alcohol do you consume in a week? _____

Have you ever used drugs recreationally? _____ If yes, please describe type, frequency and date of last use:

_____
_____

Have you ever misused prescription or over the counter drugs? _____ If yes, please describe type, frequency and date of last use: _____

_____
_____

Family History

Do you or any members of your family experience:	You/ Family Member(s):
Problems with anxiety: _____	_____
Problems with depression: _____	_____
Alcohol/substance abuse: _____	_____
Psychiatric illness: _____	_____
Trouble with the law: _____	_____
Seizures/Other neurological problems: _	_____
Tourette's syndrome/tic disorders: ____	_____
Thyroid problems: _____	_____
Attention problems: _____	_____
Learning disabilities: _____	_____
Eating disorders: _____	_____
Physical abuse: _____	_____
Sexual abuse: _____	_____
Emotional abuse: _____	_____

Family relationships

Parents: Age: Alive/deceased: Cause of Death: Quality of your relationship:

_____
_____

Siblings: Age: Alive/deceased: Cause of Death: Quality of your relationship:

_____
_____
_____
_____

Please provide any additional information/issues you want me to be aware of as we begin working together: