

**Dr. April J. Perrymore, Psy.D**  
**Licensed Psychologist**  
**PA(PS015695) NY(016057)**

**1. Contact Information**

Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

How and when do you prefer to be contacted: \_\_\_\_\_

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?  Yes  No

If yes, please explain: \_\_\_\_\_

Have you ever taken medications for psychiatric or emotional problems?  Yes  No

If yes, please explain: \_\_\_\_\_

Reason for today's appointment: \_\_\_\_\_

How did you hear of this practice:  Web  Referral  Other: \_\_\_\_\_

**2. Employment Information**

Are you currently employed or in the military?  Yes  No

Position: \_\_\_\_\_ Length of employment: \_\_\_\_\_

**3. Educational Information**

Please indicate highest level of education completed.

GED  High School  Trade School  College  Graduate

Highest Degree: \_\_\_\_\_ Certifications: \_\_\_\_\_

**Dr. April J. Perrymore, Psy.D**  
**Licensed Psychologist**  
**PA(PS015695) NY(016057)**

**4. Medical Information**

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Please list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, convulsions, seizures and/or any other medical conditions you have had since childhood.

<b>Age</b>	<b>Illness</b>	<b>Treatment</b>	<b>Result</b>

Do you have any allergies?     Yes     No

If yes, please them: \_\_\_\_\_

Please list all prescribed and over the counter medications, drugs or other substances (vitamins, herbs) you take or have taken in the last year.

<b>Drug</b>	<b>Dose</b>	<b>Reason</b>	<b>Taking Presently</b>

What type of physical exercise do you get daily? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Dr. April J. Perrymore, Psy.D**  
**Licensed Psychologist**  
**PA(PS015695) NY(016057)**

Do you restrict your eating in any way?

Yes  No

If yes, how & why? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any problems sleeping?

Yes  No

If yes, please explain. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever injected drugs?

Yes  No

Have you ever shared needles?

Yes  No

Have you ever felt the need to cut down on your drinking?

Yes  No

Have you ever felt annoyed by criticism of your drinking?

Yes  No

Have you ever felt guilty about your drinking?

Yes  No

How much beer wine or hard liquor do you consume on average each week? \_\_\_\_\_

How much tobacco do you smoke or chew each week? \_\_\_\_\_

Have you ever used inhalants such as glue, gasoline or paint thinner?

Yes  No

Have you used medications not prescribed for you in the past ten years?

Yes  No

If yes, please provide details about your use of drugs or chemicals, such as amounts, how & why you used them. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Dr. April J. Perrymore, Psy.D**  
**Licensed Psychologist**  
**PA(PS015695) NY(016057)**

**5. Family & Social Information**

**Please fill in the following information for significant family members.**

<b>Relative</b>	<b>Name</b>	<b>Living/ Deceased</b>	<b>Illnesses</b>	<b>Occupation</b>
Father				
Mother				
Stepparents				
Grandparents				
Uncles/Aunts				
Brothers				
Sisters				
Other				

**Please fill in the following information for significant nonmarital relationships.**

<b>Name</b>	<b>Age</b>	<b>Relationship Status</b>	<b>Relationship Issues</b>

**Dr. April J. Perrymore, Psy.D**  
**Licensed Psychologist**  
**PA(PS015695) NY(016057)**

**Please fill in the following information for marital relationships.**

Name	Age	Relationship Status	Relationship Issues

**Please fill in the following information for your children or stepchildren.**

Name	Age	Relationship Status	Relationship Issues

Please describe you parents' relationship with each other. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe your relationship with each parent. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe your parents' physical health, drug or alcohol use and mental or emotional difficulties. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe you relationship with your brothers and sisters. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Dr. April J. Perrymore, Psy.D**  
**Licensed Psychologist**  
**PA(PS015695) NY(016057)**

Please describe you relation with your present spouse or partner. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe you relationship with your children or stepchildren. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were you ever abused?  Yes  No

If yes, please explain the circumstances, include the age you were when the abuse started, if it was emotional or physical, by whom and the effects on you.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you currently involved in any legal cases or lawsuits?  Yes  No

If yes, please explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were you ever arrested or charged with a crime.  Yes  No

If yes, please explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Thank you for your time in completing this form.*  
***This is a strictly confidential patient medical record.***