WRIGHT WELLNESS
www.wrightwellness.me
1398 W. Mayfield Rd., Suite 220
Arlington, TX 76015
office@wrightwellness.me
682.777.4325

PATIENT INFORMATION

Today's date: _____/_____/_____

Identification

Legal Name:_____ Age:_____Date of Birth:____/____/_____

Preferred Name:_____Sex (only required for insurance):_____

Gender Identity: _____Preferred Pronouns:_____

Race & Ethnicity:_____

Race & Ethnicity Details: _____Preferred Language:_____

Home street address:_____

City/State/Zip:_____

Phone (Primary):_____ Email: _____

Calls/texts/e-mails will be discreet, but please indicate any restrictions:_____

Occupation /Employment status:_____

Military Experience:_____Education:_____

Relationship status: _____Children: _____

Closest Relationships

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Emergency Contact

If an emergency arises and we cannot reach you directly and we need to reach someone close to you, whom should we call? By listing someone below, you give permission for them to be contacted in the case of an emergency:

#1 Name: _____

Phone: _____ Relationship: _____

Address: _____

#2 Name: _____

Phone: _____ Relationship: _____

Address: _____

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Primary Medical Care (A signed release is required for treatment coordination)

Primary Care Provider_____

Location/Phone_____

Legal History

Are you presently suing anyone or thinking of suing anyone? ❑ Yes ❑ No If yes, please explain:

_____

Is your reason for coming to see us related to an accident or injury? ❑ Yes ❑ No If yes, please explain:

_____

Are you required by a court, the police, or a probation/parole officer to have this appointment?

❑ Yes ❑ No If yes, please explain: _____

Have you every had to file a complaint or been involved in a lawsuit with another mental health professional? ❑ Yes ❑ No If yes, please explain:

_____

Any other legal involvement or history? _____

_____

For minors, has this minor been named in a custody agreement, court order, and/or divorce decree? ❑ Yes ❑ No If yes, please provide a copy of this document along with other standard paperwork and all applicable adults will be contacted in accordance with this agreement. Failure to provide this information initially will result in services being stopped until documentation is obtained.

Treatment and Symptom History

I. Mental Health Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before? ❑ No ❑ Yes If yes, please indicate:

What kind? _____When?_____

From whom? _____

For what? _____

With what results? _____

Reason for stopping treatment? _____

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II. Medication(s)

Do you have a **history** of taking medications for psychiatric or emotional problems?

❑ No ❑ Yes If yes, please indicate:

What medications and dosage? _____

_____

_____

Frequency?_____

From whom? _____

For what? _____

With what results? _____

Reason for stopping treatment? _____

Do you ***currently*** take medications for psychiatric or emotional problems? ❑ No ❑ Yes If yes, please indicate:

What medications and dosage? _____

_____

_____

Frequency?_____

From whom? _____

For what? _____

For how long? _____

With what results? _____

Any **drug allergies?**

❑ No ❑ Yes If yes, please describe what type of reaction you have experienced: _____

_____

_____

_____

III. Other history

Do you have a history of abuse/neglect or any other kind of trauma, including complex trauma?

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❑ No ❑ Yes If yes, please describe what you are willing to:

_____

_____

_____

IV. Are you currently concerned about abuse or dependency of a substance and/or a behavioral addiction? ❑ No ❑ Yes If yes, please provide details about your current use and/or behaviors including amount, frequency, and reasons for use/behavior:

_____

_____

_____

V. Risk Assessment

Do you have a **history** of suicidal thoughts or attempted suicide in the past? ❑ No ❑ Yes If yes, please describe when and the circumstances: _____

_____

_____

Are you **currently** experiencing suicidal or homicidal thoughts? ❑ No ❑ Yes
Do you have a specific plan? ❑ No ❑ Yes If yes, please explain:

_____

_____

Do you have any family history of mental health conditions or past treatment? ❑ No ❑ Yes If yes, please describe what you are willing to: _____

_____

_____

Please check **all** MEDICAL conditions you **have had** or **are having**:

❑ AIDS/HIV Positive
❑ Alcoholism
❑ Anemia
❑ Anorexia
❑ Appendicitis
❑ Arthritis
❑ Asthma
❑ Bleeding Disorder
❑ Brain Injury
❑ Bronchitis
❑ Bulimia
❑ Cancer
❑ Cataracts
❑ Congestive Heart Failure
❑ Chicken Pox
❑ Dementia
❑ Diabetes
❑ Emphysema
❑ Epilepsy/Seizures
❑ Glaucoma
❑ Goiter
❑ Gout
❑ Heart disease
❑ Hepatitis
❑ Hernia

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❑ Herpes
❑ High Blood Pressure
❑ High Cholesterol
❑ Kidney Disease
❑ Liver Disease
❑ Measles
❑ Meningitis
❑ Migraine Headaches
❑ Mononucleosis
❑ Multiple Sclerosis
❑ Mumps
❑ Pacemaker
❑ Parkinson's Disorder
❑ Pelvic Inflammatory
❑ Pneumonia
❑ Polio
❑ Prostate problems
❑ Rheumatic Fever
❑ Scoliosis
❑ Sexually Transmitted Disease
❑ Stroke
❑ Thyroid Problems
❑ Tuberculosis
❑ Ulcers
❑ UTIs
❑ Other: _____
❑ Other: _____
❑Other: _____
❑ Other: _____
❑ Other: _____

Do you have a **history** of any prior surgeries? ❑ No ❑ Yes If yes, please indicate:

What years and for what reason and the outcome?_____

_____

_____

Do you have any family history of major medical health conditions? ❑ No ❑ Yes If yes, please describe what you are willing to: _____

_____

Please check all **past** and **present** PSYCHIATRIC/PSYCHOLOGICAL diagnoses.

❑ ADHD/ADD
❑ Agoraphobia
❑ Alcohol Abuse or Dependence
❑ Anorexia
❑ Anxiety Disorder
❑ Bipolar Disorder
❑ Bulimia
❑ Depression
❑ Eating Disorder
❑ Generalized Anxiety
❑ Learning Disorder
❑ Intellectual Disability
❑ Obsessive Compulsive Disorder (OCD)
❑ Panic Disorder
❑ Personality Disorder
❑ Posttraumatic Stress Disorder
❑ Psychosis
❑ Schizophrenia
❑ Substance Abuse or Dependence
❑ Behavioral Addiction (gambling, etc)
❑ Other: _____
❑ Other: _____
❑ Other: _____
❑ Other: _____
❑ Other: _____
❑ Other: _____

Please check any **current symptoms or experiences** you have had within the last month and/or have prompted you to seek services.

❑ Excessive worry
❑ Excessive anxiety
❑ Very nervous

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❑ Muscle tension
❑ Sleep disturbance
❑ Pounding heart
❑ Accelerated heart rate
❑ Obsessive thoughts
❑ Compulsive behavior
❑ Phobias/Fears
❑ Rituals
❑ Depressed mood
❑ Irritable mood
❑ Fighting and arguing
❑ Watchful/aware
❑ Startle easily
❑ Elevated mood
❑ Euphoric mood
❑ Mood swings
❑ Decreased need for sleep
❑ Shortness of breath
❑ Nausea or upset stomach
❑ Fear of losing control
❑ More talkative than usual
❑ Racing thoughts
❑ Increase in activity
❑ Excessive spending
❑ Hearing voices
❑ Seeing visions or other people/objects
❑ Unusual beliefs
❑ Increased sadness
❑ Frequent crying
❑ Loss of interest or pleasure in activities
❑ Weight loss/gain
❑ Insomnia
or of "going crazy"
❑ Fear of dying
❑ Numbness or tingling in lips/fingertips
❑ Hypersomnia
❑ Trouble concentrating
❑ Increased indecision
❑ Drinking more
❑ Smoking more
❑ Eating more
❑ Eating less
❑ Change in sex drive or satisfaction
❑ Other: _____
❑ Other: _____
❑ Other: _____
❑ Other: _____
❑ Other: _____

Chief Concern
How can we help? Please describe the main difficulty that has brought you to see us: _____

_____

_____

_____

_____

Who Referred you?

Name: _____ Phone/Email: _____

May we have your permission to thank this person for the referral? ❑ Yes ❑ No

How did this person explain how we might be of help to you? _____

Did you hear about us somewhere else? ❑ Internet ❑ Psychology Today ❑ Insurance

❑ Other_____