Anthony Iacovelli, Ph.D.
Psychotherapy, Evaluation, and Behavioral Health Services

Adult Demographic Information

Today's Date: __/__/____

Name:_____

Birth Date: __/__/____ Age: _____ Gender: _____

Address: _____ Home Phone: _____

_____ Cell Phone: _____

Email: _____

Which is your preferred method of contact? (please circle) Home Phone Cell Phone

What is a good time of day to reach you? _____

Reasons for Referral

Who referred you? _____

Briefly describe the reason you are here: _____

_____

_____

_____

How long has this reason been noticeable to you? _____

How old were you when the symptoms first occurred? _____

How often do you notice the problem? _____

What areas of your life are most affected and how (i.e. relationships, work, home)?

_____

_____

_____

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516-279-3403

Diagnoses (Yes No) If yes, please explain: _____

_____

_____

What is the name of the doctor that made the diagnosis?_____

Are you currently taking any medications (including psychiatric/behavior medications)? (Yes No)

If yes, please write name(s) and dosage: _____

_____

What is your family/household composition and names of family members living in the home (i.e. lives with spouse, parents, children)?

_____

_____

Medical History

Do you have any current medical or health concerns (Yes No) If yes, please list:

_____

_____

Do you have any chronic or recurrent medical or health concerns (i.e. diabetes, asthma)? (Yes No) If yes, please list:

_____

_____

Are you currently taking any medications for your medical condition? (Yes No) If yes, please list:

_____

_____

Have any other family members shown similar difficulties or challenges? (Yes No) If yes, who?

_____

_____