Date:_____

1. Your full name:_____Age:_____
2. Home address:_____

   _____Email:_____
3. Phones: Cell:_____ Home: _____ Work: _____

   Spouse's Cell: _____ Home Fax: _____
4. Place of birth:_____Date of birth:_____
5. Occupation: _____
6. Employer's name and address:_____

   _____
7. Name of spouse/significant other:_____Age:_____
8. Occupation:_____ Prior Occupation:_____
9. Spouse's employer's name & address:_____

   _____
10. Referred to doctor by: _____

MARITAL HISTORY:

Marital status: single married separated divorced widowed

Previous marriages:

Ex-Spouse First Name	Years Married	Age @ Marriage	Age @ Seperation	Age @ Divorce	Number of Children

EDUCATION:

What was the highest grade you completed in school?

School name? Degree? Year?

Please list any other schools you have attended.

Did you ever skip or repeat a grade? No ☐ Yes ☐ Which one?

Have you had any technical training in addition to formal schooling?

RELIGION:

In what religion were you raised?_____
What is your present religious preference?_____
Religion of spouse?_____
To what degree are you now or have you been religious? Please explain.

FAMILY:

	First Name	Age	Marital Status	Occupation	H e a l t h Problems
Mother					
Father					
Sisters & Brothers (oldest first)					
Spouse					
Children (oldest first)					

Which family members (mother, father, sisters, brothers, grandparents, aunts, uncles, cousins) have been treated for emotional problems:

Relationship	Problems (e.g. depression, alcohol, suicide, hospitalizations)

In case of emergency, please name closest relative not living with you:

Name: _____

Address: _____

Home Phone: (___) ____-_____ Work Phone: (___) ____-_____

HEALTH SURVEY:

Health Problems: Please list your major health problems past and present.

Medicines: Please list any medications you take regularly or intermittently.

Name	Does	Frequency	For what Problem

List any other drug, herb, or vitamin taken more than once a week.

Allergies: Please list any drug or medicine to which you may be allergic.

Doctors:

Name	Specialty	Phone	Major Medical Problems

PSYCHOLOGICAL PROBLEMS:

If you have seen a psychiatrist or other counselor for emotional problems before, please list.

Name	Degree	Years Seen	City, State	Phone

If you have ever been hospitalized for an emotional problem, list the hospital name, year, and city.

Hospital Name	Year	City

Do you have ideas, images, or impulses you can't get out of your mind? (Y / N)
Are there things you must do over and over again, even if they don't make sense? (Y / N)
Do you or anybody in your family have tics? (Y /N) Do peculiar odors occur to you? (Y / N)
Problems with nail-biting, gambling things that are too embarrassing to talk about? (Y / N)

Have you ever - (if yes to any, please describe)

1. assaulted someone? Yes _____ No _____
2. attempted suicide? Yes _____ No _____
3. been arrested? Yes _____ No _____

DRUG USE:

Alcohol overuse at times? Yes _____ No _____
Have you ever been worried about your drinking? Yes _____ No _____
Has anyone who knows you ever been worried about your drinking? Yes _____ No _____
Have you ever felt the need to cut down on drinking? Yes _____ No _____
Have you ever felt annoyed by criticisms of drinking? Yes _____ No _____
Have you ever had guilty feelings about drinking: Yes _____ No _____
Have you ever taken a morning eye opener? Yes _____ No _____

Cigarettes - number of packs per day _____

Coffee - number of cups per day_____

Circle non-prescribed drugs used in the last year, *Underline* non-prescribed drugs if ever used in the past.

1. marijuana, mushrooms, LSD, peyote, mescaline, nitrous oxide
2. sleeping pills, ludes, downers, reds, yellows
3. diet pills, Dexedrine, Ritalin, uppers, whites, speed, bennies, cocaine, ecstasy (MDMA)
4. codeine, morphine, Dilaudid, Darvocet, Percocet, Vicodin, heroin, opium
5. list any other drug, vitamin, or herb you take more than once a week

If female: now pregnant? Y N date of last period? post-menopausal? Y N
wish to become pregnant? Y N type of birth control : _____

OFFICE POLICIES

APPOINTMENTS

Your time is reserved for you on a regular basis. Appointments canceled in less than 48 hours will be charged at the usual rate and are not generally covered by insurance.

TELEPHONE CALLS

Your calls will be promptly returned. If you have an emergency, follow the voice mail instructions. Routine calls are welcome; longer calls will be billed on a time basis.

BILLING

You are personally responsible for direct payment of bills by the 15th of the month following your visit. When insurance coverage is involved, please submit the bill you receive to your insurance company for reimbursement. If payment is not received by 15th of each month, future payments will be requested at time of visits. Nonpayment at time of such visits incurs a 10% surcharge.

INSURANCE

Kenneth Woodrow, M.D. may furnish to your insurance company or its agents information required concerning your condition for reimbursement of medical services rendered. Charges for time required to fill out case management review forms or medication preauthorization forms sometimes requested by insurers are usually not reimbursed by the insurance company and are your personal financial responsibility.

EMAIL

Messages should be left at the office phone, 650 324-1500. If email is used by you (in rare circumstances when mutually agreed upon), be aware that they are not considered secure and private under HIPAA regulations. If you do use email, it is best to limit content to information you regard as non-sensitive.

VIDIO CONFERENCING

Video visits via Facetime or Zoom may not be totally secure or confidential. By signing below you acknowledge and agree to the risk involved.

NOTICE

California requires the following notice to consumers: I am a medical doctor and Medical doctors are licensed and regulated by the Medical Board of California (800) 633-2322, www.mbc.ca.gov.

RECORDS RELEASE

Kenneth Woodrow, M.D. is authorized to release information regarding your treatment to other physicians or therapists involved in your care.

CONFIDENTIALITY

Certain circumstances are exceptions to the general rule of confidentiality. A physician is legally required to report: intent to harm another person, child abuse, abuse of an elder or dependent adult, or sexual abuse by a prior psychotherapist.

I have read this statement and agree to its provisions.

SIGNATURE: _____ Date _____

CA Driver's License # _____

Social Security Number_____

In the space below, please draw a person. (Not a stick-figure.)

CURRENT LIFE SITUATION:

Please describe your present major symptoms, problems or complaints:

When did it start?

What made you seek psychiatric help now — rather than a week, a month, or a year ago?

What persons, situations, activities, time, etc., seem to set these problems off or make them worse?

With whom do you currently live?

Name	Age	Relationship

What are your **spouse's** (or significant other's) best five traits?

What are your **spouse's** (or significant other's) worst five traits?

Other important people in your life and their relationship to you:

Use at least five adjectives to describe what your **mother** was like when you were growing up:

Use at least five adjectives to describe what your **father** was like when you were growing up:

PERSONALITY SKETCH:

Please use at least five adjectives to describe yourself as a person:

What do you think of your looks?

What was your childhood like?

If you could change the way you grew up, what would you change?

Check items below that apply to your present condition:

(S)	(A)	(D)
_____ headaches	_____ feel tense or on edge	_____ can't get interested
_____ dizziness	_____ unusual thoughts	_____ always worried
_____ choking feeling	_____ bad temper	_____ lost appetite
_____ blurred vision	_____ panicky feelings	_____ weight change
_____ stomach trouble	_____ memory problems	_____ always tired
_____ bowel trouble	_____ trouble concentrating	_____ feel like crying
_____ muscular aches	_____ embarrass easily	_____ feel worthless
_____ pounding heart	_____ fear things I shouldn't	_____ can't make decisions
_____ sweating	_____ strong dislike of criticism	_____ procrastination
_____ smell peculiar odors	_____ can't make/keep friends	_____ thoughts of suicide
_____ sexual problems	_____ nightmares	_____ sleep intermittently
_____ loud snoring	_____ hard falling asleep	_____ wake up too early
_____ daytime drowsiness	_____ home problems	_____ feel lonely
_____ tremors or tics	_____ fear losing self-control	and depressed

Is any time of the day, week, month, or year particularly hard for you?

What kind of people are especially irritating to you?

How do you deal with your anger?

How do you deal with other people's anger?

What kinds of activities give you real pleasure?

What are your **best traits**? (What would a person who knows you well say if he were asked to describe your strong points?)

What are your **worst traits**? (What would a person who knows you well say if he were asked to describe your weak points?)

What do you think of yourself? What are you really like inside?

What would you like to be like? What would you like to change about yourself?

What are your hopes for the future? What kind of person would you like to be five years from now, and what would you like to be doing?

What else about yourself would help me to understand you better?

Do you have any comments or suggestions about this questionnaire? I know it's quite long. Thank you.