

Client Background Information and Preferences

Please know that the information you provide here is protected as confidential information. If you are unsure about a particular question, please leave it blank and we will discuss it later.

Name: _____ Date: _____

Birth Date: _____ Age: _____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Never Married ☐ Married ☐ Domestic Partnership
☐ Separated ☐ Divorced ☐ Widowed

Address to which Dr. Zook may send correspondence:

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone numbers at which Dr. Zook may reach you:

Home: _____ Is it ok to leave a message at this number? ☐ Yes ☐ No

Work: _____ Is it ok to leave a message at this number? ☐ Yes ☐ No

Cell: _____ Is it ok to leave a message at this number? ☐ Yes ☐ No

E-mail address to which correspondence may be sent: _____

*Please know that e-mail correspondence is not considered to be a trustworthy medium for confidential communication.

Emergency contact: _____ Phone: _____

Relationship to client: _____

JEFFREY ZOOK | DOCTOR OF CLINICAL PSYCHOLOGY
LICENSED CLINICAL PSYCHOLOGIST PSY.D. PSY 26522

9920 PACIFIC HEIGHTS BLVD.
SUITE 150
SAN DIEGO, CA 92121

OFFICE | 619-403-9399
FAX | 619-452-1250
JEFF@DOCTORZOOK.COM
WWW.DOCTORZOOK.COM

How did you hear about Dr. Zook? _____

How would you briefly describe the main issues for which you are seeking help?

On the scale below, please estimate the severity of these issues:

- ☐ Not a problem for me, only for other people.
- ☐ Mildly upsetting to me.
- ☐ Moderately upsetting to me.
- ☐ Severely upsetting to me.
- ☐ Extremely upsetting to me.

When did these issues begin? _____

How have you tried to resolve these issues? _____

Are you currently working with another therapist? ☐ Yes, Name: _____

☐ No

Have you previously received any kind of mental health services? ☐ Yes ☐ No

If you have, please provide the following information regarding these services:

Name of therapist	Dates of therapy	Issue(s) treated
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_____	_____	_____
_____	_____	_____
_____	_____	_____

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Have you ever been prescribed psychiatric medication? ☐ Yes ☐ No

If you have, please provide the following information regarding these medications:

Medication Name	Dose	Date Medication Started	Stopped Medication

Have you ever been treated in a psychiatric hospital or in-patient setting? ☐ Yes ☐ No

Has anyone in your family ever:

Suffered from depression? ☐ Yes, relation: _____

☐ No

Been diagnosed with bipolar disorder? ☐ Yes, relation: _____

☐ No

Threatened to commit suicide? ☐ Yes, relation: _____

☐ No

Committed suicide? ☐ Yes, relation: _____

☐ No

Had problems with drugs or alcohol? ☐ Yes, relation: _____

☐ No

Been diagnosed with schizophrenia? ☐ Yes, relation: _____

☐ No

Suffered from panic attacks? ☐ Yes, relation: _____

☐ No

Suffered from an eating disorder? ☐ Yes, relation: _____

☐ No

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Have you ever felt the need to cut down on your drinking or drug use? ☐ Yes ☐ No

Have other people ever criticized your drinking or drug use? ☐ Yes ☐ No

Have you ever felt guilty about the amount of drinking or drugs used? ☐ Yes ☐ No

Have you ever used alcohol or drugs in the morning to get going? ☐ Yes ☐ No

Have you ever had treatment for drug or alcohol issues? ☐ Yes ☐ No

Are you currently taking any medication for physical concerns? ☐ Yes ☐ No

If you are, please provide the following information regarding these medications:

Medication Name	Dose	Date Medication Started
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any significant physical medical conditions in the past or presently? ☐ Yes ☐ No

If so, please provide the following information regarding these conditions:

Medical Condition	Date of Onset
_____	_____
_____	_____
_____	_____
_____	_____

What is the date of your last physical examination? _____

How many times a week do you exercise? _____

How would you rate your sleep each night? ☐ Poor ☐ Good ☐ Excellent

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Are you currently employed? ☐ Yes ☐ No

If you are, what do you do for work? _____

What kind of work have you done in the past? _____

Have you ever served in the military? ☐ Yes ☐ No

If you have, what branch of service? ☐ Air Force ☐ Army ☐ Coast Guard

☐ Marines ☐ National Guard ☐ Navy

Dates of service: Inducted _____ Discharged _____

Highest rank achieved: _____ Combat? ☐ Yes ☐ No

Type of discharge: _____ Wounded? ☐ Yes ☐ No

What kind of schools have you attended? Please check all that apply:

☐ College or university

☐ Continuation school

☐ Graduate or professional school

☐ Independent learning center

☐ Parochial or religious school

☐ Private schools

☐ Public schools

☐ Special education classes

☐ Technical school

☐ Trade school

How would you describe yourself as a student? ☐ Below average

☐ Average

☐ Above average

What subjects were you good in? _____

What subjects were difficult for you? _____

What do you consider to be some of your personal strengths? _____

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