**Tom Cicciarelli, Psy.D. – PSY17298**
**350 Parnassus Ave, Suite 601A**
**San Francisco, CA 94117**
**415-767-5199**

---

## Biographical Information

Today's Date: _____/_____/_____

First Name:_____ Last Name:_____

Date of Birth:_____/_____/_____

Current Relationship Status:_____

Current Living Situation: ☐ live alone ☐ with partner or spouse
☐ with roommate(s) ☐ with parents or other family members
☐Other, specify:_____

Last school grade completed or highest degree earned:_____

Occupation (current or former):_____

Current Employment Status: ☐ full-time ☐ part-time ☐ student
☐ not employed outside the home ☐ retired

Date of retirement if applicable: _____/_____ (month/year)

How long at present job, if applicable:_____

Military Service:_____

How long have you lived in the Bay Area?_____

**Tom Cicciarelli, Psy.D. – PSY17298**
**350 Parnassus Ave, Suite 601A**
**San Francisco, CA 94117**
**415-767-5199**

---

## Health and Social History – Page 1

How would you describe your physical health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

| | No | Yes | Details |
|---|---|---|---|
| **Any significant medical problems, now or in the past?** | | | |
| **Any chronic or recurring medical Conditions?** | | | |
| **Have you ever been hospitalized for medical reasons?** | | | |
| **Have you ever been hospitalized for psychiatric or mental health reasons?** | | | |
| **Have you experienced any other significant medical issues (serious injuries, head trauma, surgeries, etc)?** | | | |
| **Are you currently taking any medication including psychiatric medication?**<br><br>*Please list names and dosages of all current medications; including any over-the-counter medications or herbal supplements.*<br><br>**Continue on other side of page if necessary* | | | **Name of Medication** **Dosage**<br>1.)_____<br>2.)_____<br>3.)_____<br>4.)_____<br>5.)_____<br>6.)_____<br>7.)_____ |

**Tom Cicciarelli, Psy.D. – PSY17298**
**350 Parnassus Ave, Suite 601A**
**San Francisco, CA 94117**
**415-767-5199**

## Health and Social History – Page 2

| | No | Yes | Details |
|---|---|---|---|
| **Have you taken psychiatric medications in the past?** | | | |
| **Do you currently consume alcohol and/or recreational drugs?**<br><br>*If yes, list substance, frequency, and amount.* | | | |
| **Did you previously consume alcohol and/or recreational drugs?**<br><br>*If yes, list substance(s), frequency, and amount.*<br><br>*Please also include duration of current sobriety if in recovery.* | | | |
| **Do you have any previous suicide attempts, self-destructive or violent behaviors?**<br><br>*If yes, please provide dates of any suicide attempts, violent acts, or relevant legal actions.* | | | |
| **Have you ever been injured or hurt by someone who was physically or sexually abusive to you?** | | | |

**Tom Cicciarelli, Psy.D. – PSY17298**
**350 Parnassus Ave, Suite 601A**
**San Francisco, CA 94117**
**415-767-5199**

---

**Physical and Mental Health Care**

Do you have a primary care physician (or clinic)? ☐ No ☐ Yes
If yes:

Physician (Clinic) Name: _____

Physician Address: _____

Physician Phone: _____

Physician Fax: _____

Have you ever seen anyone for psychotherapy? ☐ No ☐ Yes
If yes, when and for how long? *Please include dates and duration of all previous psychotherapy and brief description of prior reasons for seeking treatment.*

_____

_____

_____

Are you currently under the care of a psychiatrist, psychologist, or therapist? ☐ No ☐ Yes
If yes:

1.) Provider Name:_____

Provider Type: ☐ Psychiatrist (M.D.) ☐ Psychotherapist (Ph.D., MFT, LCSW, etc)

Provider Address: _____

Provider Phone: _____

Provider Fax: _____

*Please provide any other information you feel is important for me to know on an additional page.*

**Tom Cicciarelli, Psy.D. – PSY17298**
**350 Parnassus Ave, Suite 601A**
**San Francisco, CA 94117**
**415-767-5199**

Please briefly describe your main reasons for seeking treatment at this time:

Please add any additional information you feel would be important for me to know as we get started: