

JUDI BLOOM, PSYD.

Doctor of Clinical Psychology

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REGISTRATION:

LAST NAME: _____ FIRST: _____ MIDDLE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE(S): _____

PAGER: _____ CELL PHONE: _____

SOCIAL SECURITY NUMBER: _____ - _____ - _____ BIRTHDATE: _____ AGE: _____

OCCUPATION: _____ BUSINESS PHONE: _____

EMPLOYER: _____ BUSINESS ADDRESS: _____

REFERRED BY: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY:

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

street

city

state

zip

PHONE: _____

What is the major emotional problem or situation for which you are applying to the center?

INSURANCE INFORMATION:

INSURANCE COMPANY NAME: _____

SUBSCRIBER: _____

SUBSCRIBER ADDRESS: _____ CITY: _____ STATE: _____ ZIPCODE: _____

MEMBER #: _____ CERTIFICATE #: _____ GROUP #: _____

Phone # _____

YOUR OWN HISTORY

NEW CLIENTS

.....PLEASE FILL OUT THIS HISTORY TO ALLOW MORE TIME FOR PERSONAL ATTENTION TO YOU.
THE HISTORY COVERS ALL AREAS OF PHYSICAL CONDITION, STRESS, ATTENTION & EMOTIONS.

YOUR NAME: _____ AGE _____ DATE: _____

WHAT IS THE MAIN REASON FOR YOUR VISIT?: _____

HEALTH HISTORY:

1. PLEASE LIST ALL SUPPLEMENTS, VITAMINS, AND MEDICINES YOU ARE TAKING NOW?: _____

2. PLEASE LIST ALL THE MEDICINES (EXCEPT ANTIBIOTICS) YOU HAVE EVER TAKEN IN THE PAST?: _____

3. CHECK ANY YOU HAVE HAD BEFORE: SEIZURE HEAD INJURY CANCER MENINGITIS COMA

4. LIST ANY SERIOUS CONDITIONS YOU'VE HAD: 1) _____ 2) _____ 3) _____

5. HOW MANY TIMES WERE YOU HOSPITALIZED OVERNIGHT?: _____ WHY?: _____

6. HOW MUCH DO YOU USUALLY EXERCISE PER DAY?: 0-30 MIN. 1-2 HR. 3+ HR.

7. HOW HAS YOUR NUTRITION BEEN IN THE LAST 30 DAYS?: GOOD FAIR POOR

8. WHAT'S THE LONGEST YOU'VE EVER GONE WITHOUT SLEEPING?: _____ WITHOUT EATING?: _____

9. CHECK THE AMOUNTS OF THESE SUBSTANCES YOU USED PER DAY IN THE LAST 7 DAYS:

COFFEE: NONE 1-2 CUPS 3-4 CUPS 5-6 CUPS 7+ CUPS

TOBACCO: NONE HALF PACK 1 PACK 2 PACKS 3+ PACKS

ALCOHOL: NONE 1-2 DRINKS 3-4 DRINKS 5-6 DRINKS 7+ DRINKS

FAMILY AND SOCIAL PROFILE:

1. CHECK THE BLOOD RELATIVES THAT YOU FEEL MAY HAVE HAD PROBLEMS WITH:

	ATTENTION	LEARNING	CAREER	PANIC	DEPRESSION	ANGER	DRINK/DRUGS	ABUSE
YOURSELF	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MOTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FATHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SISTER/BROTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SON/DAUGHTER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. CIRCLE THE HIGHEST GRADE YOU FINISHED: 7 8 9 10 11 12 COLLEGE GRAD-SCHOOL INSTITUTE

3. LIST YOUR NUMBER OF MARRIAGES: _____ DIVORCES: _____ CHILDREN: _____ FRIENDS SEEN /WEEK: _____

PHYSICAL PROFILE

CHECK THE PHYSICAL CONDITIONS YOU HAVE EXPERIENCED IN THE LAST 7 DAYS: iv

- | | | |
|--|--|--|
| <input type="checkbox"/> POUNDING HEART | <input type="checkbox"/> DIZZINESS OR FAINTNESS | <input type="checkbox"/> HOT FLASHES OR CHILLS |
| <input type="checkbox"/> TREMOR OR SHAKES | <input type="checkbox"/> CHEST PAIN | <input type="checkbox"/> DETACHED FEELINGS |
| <input type="checkbox"/> EXCESSIVE SWEATINESS | <input type="checkbox"/> TINGLING FINGERS AND TOES | <input type="checkbox"/> FEAR OF LOSING CONTROL |
| <input type="checkbox"/> SHORTNESS OF BREATH | <input type="checkbox"/> CHOKING FEELING | <input type="checkbox"/> NAUSEA OR VOMITING |
| <input type="checkbox"/> UNCONTROLLABLE WORRIES | <input type="checkbox"/> FATIGUED TOO EASILY | <input type="checkbox"/> KEYED UP OR EDGY iii |
| <input type="checkbox"/> MUSCLE TENSION | <input type="checkbox"/> MIND OFTEN GOING BLANK | <input type="checkbox"/> UNSATISFYING SLEEP |
| <input type="checkbox"/> STIFF OR PAINFUL JOINTS | <input type="checkbox"/> SOFT / DETERIORATING NAILS | <input type="checkbox"/> BACK PAIN x |
| <input type="checkbox"/> JAW PAIN OR TMJ | <input type="checkbox"/> CONSTIPATION | <input type="checkbox"/> FREQUENT NEED TO URINATE |
| <input type="checkbox"/> HEADACHE | <input type="checkbox"/> DIARRHEA | <input type="checkbox"/> PAINFUL URINATION |
| <input type="checkbox"/> NECKACHE | <input type="checkbox"/> SEVERE ABDOMINAL PAIN | <input type="checkbox"/> UNABLE TO FUNCTION |
| <input type="checkbox"/> FEEL OVERWHELMED | <input type="checkbox"/> CAN'T GET TO BED UNTIL LATE | <input type="checkbox"/> FEEL LIKE JUMPING OUT OF SKIN |
| <input type="checkbox"/> PMS | <input type="checkbox"/> LOW SEX INTEREST | <input type="checkbox"/> PROBLEMS WITH ORGASM |

LIFESTYLE STRESSES

1. WHAT IS YOUR CURRENT JOB OR CAREER?: _____

2. WHAT IS THE GREATEST SOURCE OF STRESS FOR YOU, NOW?: _____

3. CHECK HOW THINGS HAVE BEEN, ON THE AVERAGE, OVER THE LAST 7 DAYS:

ABOUT HOW LONG DO YOU SLEEP EACH NIGHT? 5-9 HOURS 0-4 HRS OVER 10 HRS

HOW LONG DOES IT TAKE YOU TO FALL ASLEEP? 5-20 MINS 30 MIN-1 HR. OVER 2 HRS

HOW LONG ARE YOU AWAKE DURING THE NIGHT. 0-20 MINS 30 MIN-1 HR. OVER 2 HRS

HOW LONG ARE YOU AWAKE BEFORE THE ALARM? 0-20 MINS 30 MIN-1 HR OVER 2 HRS

YOUR WEIGHT CHANGES IN THE LAST MONTH? 0-9 LB. 10 LB. LOSS 10 LB GAIN

4. CHECK ALL THE WAYS YOU HAVE FELT IN THE LAST 7 DAYS:

SAD. HOPELESS. ANXIOUS. PANICKY IRRITABLE. LONELY EMPTY BORED

5. CHECK ALL THE WAYS YOU HAVE FELT NEARLY EVERY DAY FOR THE LAST 2 YEARS:

SAD. HOPELESS. ANXIOUS. PANICKY IRRITABLE. LONELY EMPTY BORED

EXPERIENCES YOU MAY HAVE HAD

CHECK THE AREAS THAT CAUSED YOU FREQUENT PROBLEMS IN THE LAST 2 WEEKS: vi

- | | | |
|---|--|--|
| <input type="checkbox"/> ATTENTION TO DETAILS | <input type="checkbox"/> STAYING FOCUSED | <input type="checkbox"/> LOSING THINGS |
| <input type="checkbox"/> MAINTAINING ATTENTION | <input type="checkbox"/> LISTENING TO OTHERS | <input type="checkbox"/> BEING TOO DISTRACTIBLE |
| <input type="checkbox"/> FINISHING PROJECTS | <input type="checkbox"/> ORGANIZING YOUR WORK | <input type="checkbox"/> MEMORY PROBLEMS |
| <input type="checkbox"/> FIDGETING | <input type="checkbox"/> FEELING RESTLESS | <input type="checkbox"/> INTERRUPTING OTHERS vi |
| <input type="checkbox"/> HARD TO SIT STILL | <input type="checkbox"/> TALKING EXCESSIVELY | <input type="checkbox"/> WAITING IN LINE |
| <input type="checkbox"/> CAN'T RELAX IN QUIET TIMES | <input type="checkbox"/> DRIVEN "LIKE A MOTOR" | <input type="checkbox"/> ENDING OTHERS SENTENCES |

THOUGHTS AND EXPERIENCES

CHECK ALL THE WAYS THAT YOU HAVE BEEN IN THE LAST 2 WEEKS:

- | | | |
|--|---|--|
| <input type="checkbox"/> FEELING DEPRESSED | <input type="checkbox"/> FEELING WORTHLESS | <input type="checkbox"/> SLEEP PATTERN IS UPSET |
| <input type="checkbox"/> DISINTERESTED & APATHETIC | <input type="checkbox"/> POOR CONCENTRATION | <input type="checkbox"/> EATING PATTERN IS UPSET |
| <input type="checkbox"/> FATIGUED & LOW ENERGY | <input type="checkbox"/> THINKING ABOUT DEATH | <input type="checkbox"/> EXERCISE PATTERN IS UPSET |
| <input type="checkbox"/> LOSING WEIGHT & CAN'T EAT | <input type="checkbox"/> CAN'T SLEEP LATE IN THE AM | <input type="checkbox"/> THINKING VERY SLOWLY iii |
| <input type="checkbox"/> FEELING VERY GUILTY | <input type="checkbox"/> FEEL MOST SAD IN THE AM | |
| <input type="checkbox"/> GOOD NEWS IS CHEERING | <input type="checkbox"/> ARMS & LEGS FEEL LIKE LEAD | <input type="checkbox"/> WANT TO SLEEP ALL DAY ii |
| <input type="checkbox"/> HUNGRY & GAINING WEIGHT | <input type="checkbox"/> SUPER-SENSITIVE TO REJECTION | |
| <input type="checkbox"/> WORSE IN THE WINTER | <input type="checkbox"/> CRAVE CHOCOLATE / SWEETS | <input type="checkbox"/> CAN'T GET MOTIVATED x |
| <input type="checkbox"/> DAYDREAM A LOT | <input type="checkbox"/> PANICKY IN THE MORNING | <input type="checkbox"/> JUMPING OUT OF YOUR SKIN |
| <input type="checkbox"/> FEEL OVERWHELMED | <input type="checkbox"/> FEEL UNABLE TO FUNCTION | <input type="checkbox"/> CAN'T GET TO BED EARLY |

IN THE LAST YEAR HAVE YOU HAD PERIODS LASTING MORE THAN A WEEK OF?:

- | | | |
|--|---|--|
| <input type="checkbox"/> FEELING QUITE IRRITABLE | <input type="checkbox"/> FEELING QUITE EXPANSIVE | <input type="checkbox"/> FEEL ON TOP OF THE WORLD |
| <input type="checkbox"/> MORE DARING & IMPULSIVE | <input type="checkbox"/> THOUGHTS RAPID OR RACING | <input type="checkbox"/> MUCH MORE TALKATIVE iv |
| <input type="checkbox"/> NEEDING LITTLE SLEEP | <input type="checkbox"/> QUITE EASILY DISTRACTED | <input type="checkbox"/> OBSSIVE ACTIVITIES / IDEAS |
| <input type="checkbox"/> SELF ESTEEM QUITE HIGH | <input type="checkbox"/> NOT SLEEPING FOR DAYS | <input type="checkbox"/> NOT EATING FOR DAYS x |
| <input type="checkbox"/> FEEL TREMENDOUS ENERGY | <input type="checkbox"/> WORK 10+HR/DAY FOR 6 MO | <input type="checkbox"/> MORE SEXUALLY AWARE |
| <input type="checkbox"/> WORKING ALL NIGHT | <input type="checkbox"/> BEING LOTS MORE SOCIABLE | <input type="checkbox"/> TAKE UNPLANNED TRIPS |
| <input type="checkbox"/> SPENDING UNWISELY | | |

RECENT THOUGHTS

1. HAVE UNPLEASANT THOUGHTS BEEN REPEATING OVER & OVER IN YOUR MIND?.. YES NO
 (IF YES): GIVE A BRIEF EXAMPLE: _____
2. DO SILLY OR SENSELESS IDEAS IMAGES OR IMPULSES KEEP ENTERING YOUR MIND? YES NO
 (IF YES): DO THEY WASTE A LOT OF TIME OR INTERFERE WITH YOUR LIFE?..... YES NO
 GIVE A BRIEF EXAMPLE: _____
3. DO YOU FEEL DRIVEN TO PERFORM EXCESSIVE OR SENSELESS BEHAVIORS?..... YES NO
 (IF YES): DO THEY WASTE A LOT OF TIME OR INTERFERE WITH YOUR LIFE?..... YES NO
 GIVE A BRIEF EXAMPLE: _____
4. ARE EXCESSIVE IDEAS OF UNFAIRNESS OR JEALOUSY REPEATING OVER AND OVER? YES NO
5. ARE YOU ANGRY AT ANYONE NOW?..... YES NO
 (IF YES): WHO?: _____
6. HAVE YOU BEEN THINKING LIFE WASN'T WORTH LIVING?..... YES NO
 (IF YES): HAVE YOU THOUGHT OF KILLING YOURSELF?..... YES NO
 (IF YES): HOW OFTEN?: _____ TIMES PER WEEK. HOW WOULD YOU DO IT? _____

THOUGHTS AND ACTIONS

CHECK ALL THE THINGS YOU'VE BEEN THINKING ABOUT A LOT IN THE LAST 30 DAYS:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> BEING LIKED BY OTHERS | <input type="checkbox"/> LOOKING EMBARRASSED | <input type="checkbox"/> LOOKING FOOLISH | p |
| <input type="checkbox"/> LOSING CONTROL | <input type="checkbox"/> BEING CENTER OF ATTENTION | <input type="checkbox"/> MAKING MISTAKES | |
| <input type="checkbox"/> PEOPLE HURTING FEELINGS | <input type="checkbox"/> ABANDONMENT | <input type="checkbox"/> LOYALTY | |
| <input type="checkbox"/> SUCCESS | <input type="checkbox"/> CELEBRITIES | <input type="checkbox"/> BETRAYAL | b |
| <input type="checkbox"/> FAME | <input type="checkbox"/> MYSTICISM | <input type="checkbox"/> WORRY ABOUT DISEASES | |
| <input type="checkbox"/> GOD, SPIRIT & REVELATION | <input type="checkbox"/> MAGICAL THINGS | <input type="checkbox"/> YOUR SPECIAL GIFTS | |

CHECK ANY THAT YOU HAVE DONE ON PURPOSE AS AN ADULT WHEN UPSET:

- | | | |
|--|---|--|
| <input type="checkbox"/> BINGE EATING | <input type="checkbox"/> BITING YOUR NAILS | <input type="checkbox"/> GRINDING TEETH IN AM/PM |
| <input type="checkbox"/> VOMITING TO LOSE WEIGHT | <input type="checkbox"/> PULLING YOUR HAIR | <input type="checkbox"/> CHEW MOUTH OR CHEEKS |
| <input type="checkbox"/> THROWING SOMETHING | <input type="checkbox"/> HITTING YOURSELF | <input type="checkbox"/> HITTING SOMEONE ELSE |
| <input type="checkbox"/> PUNCHING WALL OR PILLOW | <input type="checkbox"/> CUTTING/BURNING YOURSELF | <input type="checkbox"/> SUICIDE ATTEMPT (S) |

CHECK ANY YOU HAVE EXPERIENCED AS AN ADULT (WHEN NOT INTOXICATED):

- | | | |
|---|---|--|
| <input type="checkbox"/> SENSITIVE TO LOUD NOISES | <input type="checkbox"/> SENSITIVE TO BRIGHT LIGHTS | <input type="checkbox"/> TIME SLOWS & SPEEDS UP |
| <input type="checkbox"/> HEARING GETS LOUD & SOFT | <input type="checkbox"/> SEE THINGS MOVE OR FLOAT | <input type="checkbox"/> THOUGHTS SPEED & SLOW |
| <input type="checkbox"/> LOW RUMBLE IN YOUR EARS | <input type="checkbox"/> SUDDEN FEAR ATTACKS | <input type="checkbox"/> SENSE OF DEJA VUE |
| <input type="checkbox"/> A SENSE OF FLOATING | <input type="checkbox"/> AMNESIA EPISODES | <input type="checkbox"/> KNOWING THE FUTURE |
| <input type="checkbox"/> DREAMLIKE FEELING | <input type="checkbox"/> THOUGHT CONTROL | <input type="checkbox"/> SENSE OF PREDESTINATION |
| <input type="checkbox"/> LEAVING YOUR BODY | <input type="checkbox"/> SEEING VISIONS | <input type="checkbox"/> TELEPATHY |
| <input type="checkbox"/> HEARING NOISES OR VOICES | <input type="checkbox"/> SMELLING ODD SMELLS | |

IN THE LAST MONTH DO YOU GENERALLY FIND YOU ?:

- | | | |
|---|--|--|
| <input type="checkbox"/> HAVE ANGRY OUTBURSTS | <input type="checkbox"/> CAN NOT CONCENTRATE | <input type="checkbox"/> ARE EASILY STARTLED |
| <input type="checkbox"/> LOOK FOR INVISIBLE DANGERS | <input type="checkbox"/> CAN'T FALL OR STAY ASLEEP | |
| <input type="checkbox"/> FEEL DISTANT FROM OTHERS | <input type="checkbox"/> ARE COLD & UNCARING | iii |
| <input type="checkbox"/> NO PLANS FOR YOUR FUTURE | <input type="checkbox"/> HAVE NO INTEREST IN LIFE | <input type="checkbox"/> HAVE DREAMLIKE FEELINGS |

IF YOU HAVE BEEN EXPOSED TO A SEVERE TRAUMA, DO YOU?:

- | | | |
|---|--|--|
| <input type="checkbox"/> AVOID THINKING OF IT | <input type="checkbox"/> AVOID REMINDERS OF IT | <input type="checkbox"/> FORGET DETAILS ABOUT IT |
| <input type="checkbox"/> KEEP THINKING OF IT | <input type="checkbox"/> HAVE FLASHBACKS OF IT | |
| <input type="checkbox"/> GET UPSET BY REMINDERS OF IT | <input type="checkbox"/> DREAM ABOUT IT | i |