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Employee Candidate Information

Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Telephone: home _____ work _____ cell _____

Address: _____

City: _____ State _____ Zip _____ Birth Date: ____ / ____ / ____ Sex: M F

Social Security Number: ____ / ____ / ____ E-mail: _____ (not encrypted)

Marital Status: single married other

Please complete this form completely and honestly. It is essential to have very detailed information and I understand that it may feel intrusive.

Age: _____ Height: _____ Weight: _____

I. Health History (birth to present): *(additional information can be added on the back of this page)*

General Description	Illnesses & Treatments	Surgical Procedures
Childhood:		
Adolescence:		
Adulthood:		

II. Current Health:

(additional information can be added on the back of this page)

General Description	Illnesses & Treatments	Surgical Procedures

Specific difficulties: (check any that apply)

- headaches
 loss of appetite
 sedatives usage
 dizziness
 bowel disturbances
 fainting spells
 fatigue
 palpitations
 insomnia
 stomach trouble
 nightmares
 alcoholism
 allergies, describe:

(Additional information can be added on the back of this page)

Substance Intake	no	yes	frequency	amount	type
Tobacco					
Alcohol					
Non-prescription drugs					
Supplements					
Other					

Special diet (?):

III. Current medications

(additional information can be added on the back of this page)

Medication	Dosage/ Date began	Condition Prescribed for	Prescribed by	Side Effect
				Y/N describe

IV. Mental Health

Describe how you feel emotionally?

Have you sought mental health services in the past? Treatment? _____ Date(s) _____
Describe symptoms/treatment:

Current Symptoms: (check any that apply)

- | | | | |
|---|---|--|-------------|
| <input type="checkbox"/> depressed mood | <input type="checkbox"/> hopelessness | <input type="checkbox"/> paranoia | other _____ |
| <input type="checkbox"/> concentration problems | <input type="checkbox"/> inappropriate anger | <input type="checkbox"/> self-injurious behavior | _____ |
| <input type="checkbox"/> anxiousness | <input type="checkbox"/> impulsivity | <input type="checkbox"/> sexual function (neg. change) | _____ |
| <input type="checkbox"/> decreased energy | <input type="checkbox"/> irritability | <input type="checkbox"/> sleep disturbance | _____ |
| <input type="checkbox"/> grief | <input type="checkbox"/> guilt | <input type="checkbox"/> gender issues | _____ |
| <input type="checkbox"/> hyperactivity | <input type="checkbox"/> tearfulness | <input type="checkbox"/> weight change | _____ |
| <input type="checkbox"/> memory problems | <input type="checkbox"/> obsessions/compulsions | <input type="checkbox"/> worthlessness | _____ |
| <input type="checkbox"/> panic attacks | <input type="checkbox"/> elevated mood | <input type="checkbox"/> relationship problems | _____ |
| <input type="checkbox"/> feelings of suicide | <input type="checkbox"/> eating disturbance | <input type="checkbox"/> concern of substance use | |

Less than 1 month 1-6 months 7-11 months more than a year

V. Medical Tests

(or list family members with abnormal results)

Test	Date	Results
Thyroid (T3/T4/TSH)		
Hormonal levels (free testosterone/ total testosterone)		
Diabetes		
Cardiovascular Disease		
Sexually Transmitted Disease		
Other		

List any other medical problems that doctors have diagnosed (and dates).

Other illnesses or conditions within family? Parents? Grandparents? Siblings?

VI. Significant Others/ Live with/ etc.

Spouse/Partner _____ How long together? _____

Prior Marriage(s)? Dates, reason for ending, etc.

Children/Ages

_____	_____
_____	_____
_____	_____
_____	_____

VII. Family of Origin

Parents? Grandparents? Siblings? Step parents? Etc.

	Alive? or Age/Cause of Death	Where currently Living? Married?	Medical Conditions	Mental Health Treatment? Date/Diagnosis
Mother				
Father				
Siblings				

VIII. BRIEF summary of your current job description and the job description for which you are applying?

IX. Additional information that you would like to share