The Center for Dialectical and Cognitive Behavioral Therapies, LLC
291 Whitney Avenue, Suite 301
New Haven, CT 06511

Name: ______________________________________ **Age** ____ **Date of Birth** ______________________

Insurance Co. (if applicable) ________________________ **Insurance ID** ________________________

Group # ______________ ("Bill to Name" if not patient) ____

Address: ____

Street City State Zip

Preferred Phone: Home ____________________ Cell: ______________________________

email address: ____________________________________(**if we are authorized to contact you by email**? **This means you are aware that privacy cannot be assured on the internet**).

What is the best way to reach you (for example, to schedule or change an appointment)?

____

Who referred you? ____

What is your living situation? ____alone; ___spouse/partner; ____family; ____other(specify below)

Names, ages and occupations or other relevant information about those living with you (circle relevant choice/s):

Spouse/partner/parent:____

Children/sibs/other: ____

____

In case of emergency, whom should we contact?

Name: ______________________________ Relationship: _______________________________

Phone # (home) ________________ #(work) ___________________ #(cell) ________________

Briefly, what is the main problem that led you to contact us?

____

____

____

What should we know about the history of this problem? _____________________________________

____

____

____

____

What is the one most important thing you would like to get from this treatment? ________________

____

If you are currently taking any medications for this problem or other psychological or emotional issues, what are those medications and what is the daily dose?

______________________________________ ______________________________________

______________________________________ ______________________________________

Who prescribes them? ____

Do we have your authorization to request and release relevant information to/from the prescriber? _____ ***yes*** ______ ***no***

If any other psychiatric medications have been prescribed for you in the past what?:

Medication	Dosage	Was it helpful?	Why did you stop it?

If you have you been treated before for psychological/behavioral/ emotional issue, please tell us about the treatment.

Hospitals (name. date, reason and length of stay):

____

____

____

Outpatient Treatment (Therapist name, dates, was it helpful?)

____

____

____

Intoxicant use History:

In the **past month**, what intoxicants have you used?

	Yes/ No	Amount	Form (or) comment	Alone or socially	Did you think it was excessive?	Did anyone else think it was excessive? (Who?)	Earlier history?
Alcohol							
Cocaine							
Cannabis							
Ecstasy, LSD,etc							
Opiates							
Amphetamine							
Other Pills (what) ______________							
Other substance ______________							

Has the quality of your life ever been reduced by your substance use? ____yes _____no _____?

Have you ever tried to stop or reduce your substance use on your own? _____yes _____ no

Have you ever received treatment for substance abuse? _____yes _____no

If "yes," when? ____

Medical History:

What was the date of your last physical examination? ________________________________

Do you have current active medical problems? _____ No _____Yes

If "yes," what? ____

Who is your current primary care physician? _____________________________________

Do you **request** that we contact him/her to inform them about your treatment here?

____ yes ____no (If something comes up that you or we feel makes it important for us to contact your physician, we will let you know and explain. **Otherwise please check "no"**).

Social and Developmental History:

If there is anything we should be aware of that was unusual in your childhood development (for example, learning or school problems, physical development issues, stressful separations or losses, abuse, etc.), what?

____

____

____

Education:

What is the highest grade in school you have completed? ______ Where? ________________

Briefly, how would describe yourself as a student? _________________________________

____

Occupational History:

Current Occupation (check one):

____employed ____unemployed ____student ____homemaker ____retired ____disabled

If employed, employer: ____

What do you do: ____

Are there things you think we might need to know about either your current or past employment history?

____

____

Family History:

Parents living? Ages, etc. ____

Briefly describe them and your relationship (past and present)

____

____

____

Brothers and sisters (names and ages) ____

____

What might be important for us to know about them or your relationship(s) with them?

____

____

Other current relationships:

Is there anything we need to know about other current relationships? ___________________

____

I have received a copy of the "Patient-therapist Agreement" which includes federal HIPPA privacy policies. I authorize mutual release of information between CDCBT, LLC and any other professionals involved in my care as indicated above. I also authorize contact with named "Emergency contact" if my treater feels it is in my best interest. I understand that I will pay for any scheduled session unless I provide 24 hours notice. All reasonable efforts may be made to collect any fees I incur. I understand that conversations with my therapist will be confidential with certain exceptions under Connecticut law. These include the therapist's obligation to report actual or suspected child or elder abuse. I may request further clarification about these exceptions and will normally be informed before any action is taken under these requirements. Additional information is in the "Patient-therapist Agreement." This authorization may be cancelled in writing except to the extent it has already been acted upon.

Date: ____________________________ Signature: __________________________________

Parent (if under 16): __________________________________