LORI KLETT ROBERTO, PH.D. INITIAL QUESTIONNAIRE

| Name: | | Today's Date: | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|
| Date of Birth: | Age: Gender: | Marital Status: | | | |
| Address: | | | | | |
| Street | | City Zip | | | |
| Home Phone: () | May I leav | ve a message? Yes □ No □ | | | |
| Cell Phone: () | May I leav | ve a message? Yes □ No □ | | | |
| E-mail: | Permission | to contact via email? Yes □ No□ | | | |
| Work Status: □Full-Time □Par | rt-Time □Student □Hor | memaker □Retired □Disabled □Other | | | |
| Employer | Occupation | Work/shift hours | | | |
| Do you have Medicare or are you | u Medicare eligible? Yes | □ No □ | | | |
| Emergency contact: | mergency contact: Relationship to you | | | | |
| Emergency Contact's Phone: (|) | | | | |
| Your major reasons for seeking | g help? | | | | |
| | - | | | | |
| What are your goals? | | | | | |
| | | | | | |
| Are you in current mental health | treatment? Yes □ No □ | If yes, with | | | |
| Have you been in previous thera | py or mental health treatme | ent? Yes \square No \square | | | |
| Have you ever been in alcohol or | - · | | | | |
| Have you ever had any psychiatr | | | | | |
| □ Anxiety □ Alcohol/Drug prob □ Compulsions □ Depression □ Learning Disorder □ Legal Properties violence □ Prejudice/Inju Abuse/Molestation □ Self-Harm | elem □Bipolar Disorder □ □Eating Disorder or Concoblems □Obsessive Thousestice □Problems in School □ Sleep Problems □Su□Thoughts of hurting some | nghts □ Overweight/Obesity □ Partner/do- ol/Work □ Seeing unusual things □ Sexual uicidal Thoughts in Past □ Suicidal Thoughts cone □ Trauma □ Unwanted sexual experi- | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| What do you see as your personal strengths? | | | | |
|------------------------------------------------------------|----------------------------------------------------------------------|-------------------------------------------------------------------------------|---------------------------------|--|
| | | | | |
| Health Information: Major past or current health problems: | | | | |
| Physician(s): | | | | |
| Current MedicationsIn Name of medication | | | pplements: Frequency/how often? | |
| | | | | |
| Living & Family Inform Who lives in your househ | a ation: old? | | | |
| Spouse/Partner Name: | | Age: Occ | rupation: | |
| Do you have any children | ? (including foster, step | p, etc.) Please list names | & ages: | |
| Your ethnic/cultural ident | ity | Religious l | oackground | |
| Who raised you? | | | | |
| Where did you grow up? | | | | |
| Brothers/sisters (include s | step/adopted/half) | | | |
| □ Bipolar Disorder □ De □ Eating Disorders □ L | epression □ Death/Los egal problems □ Pare s □ Sexual Abuse/Mo | sses in family □Disabili ent Unemployment □Psy lestation □ Suicide or a | | |

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Acknowledgement and Signature Page

(Please initial each section and sign and date at bottom)

| 1. | I have received "Welcome to my Practice: Informed Consent for Services & Office Policy Agreement" from Dr. Lori Roberto: | | | |
|-------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|
| 2. | I understand there is a 24 hour cancellation/reschedule policy and that I will be responsible for the fee of \$150 for missed or late cancelled sessions: | | | |
| 3. | I understand that Dr. Lori Roberto is not contracted with and does not bill insurance companies on my behalf, and that she is not a Medicare provider: | | | |
| 4. | I have received "HIPAA Notice of Privacy Practices" from Dr. Lori Roberto: | | | |
| 5. | I understand there are exceptions to confidentiality where it may be necessary or required by law to disclose information without my written permission: | | | |
| Pra "H rai ter | y signature below indicates that I have read the information in the "Welcome to my actice: Informed Consent for Services & Office Policy Agreement" as well as the IIPAA Notice of Privacy Practices" from Dr. Lori Roberto. I acknowledge that I have sed any questions I have about these documents, and that I agree to abide by their ms (freely and without reservations) during this professional relationship. My signate represents an agreement between myself and Dr. Lori Roberto. | | | |
| Sig | gnatureDate | | | |
| Dri | inted Name | | | |