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 leave a message? Yes ☐ No ☐

Cell Phone: (____)____________________ May I leave a message? Yes ☐ No ☐

E-mail: ______________________________ Permission to contact via email? Yes ☐ No ☐

Work Status: ☐ Full-Time ☐ Part-Time ☐ Student ☐ Homemaker ☐ Retired ☐ Disabled ☐ Other

Employer______________________ Occupation _________________ Work/shift hours __________

Do you have Medicare or are you Medicare eligible? Yes ☐ No ☐

Emergency contact: _______________________________ Relationship to you__________________

Emergency Contact's Phone: (____) __________________________

Your major reasons for seeking help? ____

____

What are your goals? ____

____

Are you in current mental health treatment? Yes ☐ No ☐ *If yes, with* ________________________

Have you been in previous therapy or mental health treatment? Yes ☐ No ☐

Have you ever been in alcohol or substance abuse treatment? Yes ☐ No ☐

Have you ever had any psychiatric hospitalizations? Yes ☐ No ☐

Have you experienced any of the following? ☐ Abuse/Neglect ☐ ADHD ☐ Anger Issues/Fighting ☐ Anxiety ☐ Alcohol/Drug problem ☐ Bipolar Disorder ☐ Body Image Concerns ☐ Bullying ☐ Compulsions ☐ Depression ☐ Eating Disorder or Concerns ☐ Hearing Voices ☐ Insomnia ☐ Learning Disorder ☐ Legal Problems ☐ Obsessive Thoughts ☐ Overweight/Obesity ☐ Partner/domestic violence ☐ Prejudice/Injustice ☐ Problems in School/Work ☐ Seeing unusual things ☐ Sexual Abuse/Molestation ☐ Self-Harm ☐ Sleep Problems ☐ Suicidal Thoughts in Past ☐ Suicidal Thoughts Recently ☐ Suicide Attempts ☐ Thoughts of hurting someone ☐ Trauma ☐ Unwanted sexual experience ☐ Worry too much ☐ Other ***Briefly explain checked items***:

____

____

____

What do you see as your personal strengths? ______________________________

____

____

Health Information:
Major past or current health problems: ______________________________

____

____

Physician(s): ______________________________

Current Medications--Including over the counter medicine, herbs and supplements:

Name of medication	Purpose?	Dose?	Frequency/how often?

Living & Family Information:
Who lives in your household? ______________________________

Spouse/Partner Name: ______________ Age: ______ Occupation: ______________

Do you have any children? (including foster, step, etc.) Please list names & ages:

____

Your ethnic/cultural identity ______________ Religious background ______________

Who raised you? ______________________________

Where did you grow up? ______________________________

Brothers/sisters (include step/adopted/half)______________________________

____

Is there a <u>Family History</u> of any of these? ☐ Abuse/Neglect ☐ Alcohol/Drug problems ☐ Anxiety ☐ Bipolar Disorder ☐ Depression ☐ Death/Losses in family ☐ Disability ☐ Domestic Violence ☐ Eating Disorders ☐ Legal problems ☐ Parent Unemployment ☐ Psychiatric Hospitalization ☐ Serious medical illness ☐ Sexual Abuse/Molestation ☐ Suicide or attempts ☐ Trauma ☐ Other

Please explain checked items and note family member*:*

____

____

____

Acknowledgement and Signature Page

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

1. I have read "Welcome to my Practice" which includes the Informed Consent for Services & Office Policy Agreement and the HIPAA Notice of Privacy Practices for Dr. Lori Roberto. This document remains available for review on Dr. Roberto's website: __________

2. I understand there is a 24 hour cancellation/reschedule policy and that I will be responsible for the fee of $160 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 understand there are exceptions to confidentiality where it may be necessary or required by law to disclose information without my written permission: __________

My signature below indicates that I understand the information in the "Welcome to my Practice" which includes the Informed Consent for Services & Office Policy Agreement as well as the HIPAA Notice of Privacy Practices from Dr. Lori Roberto. I acknowledge that I have raised any questions I have about this document, and that I agree to abide by its terms (freely and without reservation) during this professional relationship. My signature represents an agreement between myself and Dr. Lori Roberto.

Signature ____ Date __________________

Printed Name ____