ERICA D. PRINCE, PHD, LLC
LICENSED PSYCHOLOGIST

Name_____Date of Birth:____/____/____
Address_____
Email_____ok to email?_____
Phone_____msg ok?____Other phone_____msg ok?____

Insurance Policy Information

Policy Holder Name_____Date of Birth_____
Relationship to patient_____
Primary Insurance _____
ID#_____ Group #_____
Deductible _____ Copay _____
Secondary Insurance (if applicable) _____
ID# _____ Group # _____

Authorization

I authorize the release of any medical or other information necessary to process insurance claims. I also authorize payment of insurance/medical or other benefits to Erica Prince, PhD, LLC

Patient Date

Financial Policy

Note: If you are a private pay patient, your insurance company will not be billed for visits.
Please initial each of the following:

_____ Patient is ultimately responsible for the *total cost* of services provided
_____ Copay, if in policy, is expected at each visit
_____ Session charge is due at each visit (for patient not covered by insurance)
Session rate: $272.00 Diagnostic session; $180 all other sessions unless otherwise negotiated
_____ Deductibles are responsibility of patient at *Session Rates* above.

For office use only

Diagnosis _____ Ins ____ Self pay ____ EPA ____ Other ____

Name:_____

2. *Presenting Problem*

Describe the problem(s) that brought you here today:

Check any of the symptoms that you have been having:			
Depressed mood		Feeling hopeless	
Extreme sadness		Tearful and/or crying spells	
Trouble concentrating		Memory problems	
Change in sleeping habits		Lack of energy	
Diminished interest in activities		Seeing or hearing things that others do not	
Change in eating habits		Weight or appetite changes	
Problems getting along with family		Problems getting along with friends	
Inability to enjoy usual activities		Feelings of extreme happiness	
Trouble doing usual work		Racing thoughts	
Feeling stressed		Irritable	
Low self-esteem		Isolation or withdrawal	
Perfectionistic		Feeling guilty	
Worries		Feeling nervous	
Physical complaint of pain		Sudden feelings of panic	
Angry outbursts and/or acting violent		Tense or uptight	
		Feeling fearful	
Feeling worthless		Pounding heart	
Has hurt or cut on self		Trembling or shaking	
Thoughts of killing self		Thoughts of killing others	

(This space is reserved for additional comments by clinician.)

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Name:_____

3. *What has been done about this problem so far?*

Have you been in counseling before? Yes ☐ No ☐
If you have been in counseling before, please describe it below. Please include the name(s) of the therapist(s), the dates, and the issues for which you were seeking treatment.
Have you, in the present or past, been prescribed any psychiatric medications? Yes ☐ No ☐
If yes, please describe: Dates:

4. *Substance use History* (If Applicable)

Do you use tobacco (any form)?	Current	In the Past	No
Do you use alcohol?	Current	In the Past	No
Do you use caffeine (any form, including cola drinks)?	Current	In the Past	No
Do you use recreational drugs?	Current	In the Past	No
Do you use any other over-the-counter medications or herbal remedies?		Yes	No
Name of Remedy	Purpose		

Continued on following page

Name:_____

5. *Medical Information*

Have you seen a doctor within the last year?	Yes	No
What was that for?		
Who is your primary care physician?	Phone:	
Is your primary care physician aware that you are seeking therapy?	Yes	No
Please list any prescribed medications you are currently taking:		
Please list any major medical problems you have had such as chronic illness, serious illness, operations, injuries or trauma to the head, etc.:		
Do you have any allergies to anything?	Yes	No
Describe any allergy problems that you may have:		
Do you have problems with sleeping?	Yes	No
Do you have problems with eating?	Yes	No
Do you have problems getting along with others?	Yes	No
Describe the problem(s):		
Have you been affected by any issues such as witnessing violence, having accidents, experiencing loss, or experiencing abuse (physical, sexual, or emotional?)	Yes ☐	No ☐
Please describe relevant the trauma(s):		

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Name:_____

6. *Developmental History*

Briefly describe your childhood:		
Have you been divorced or separated?	Yes	No
Have there been any mental health problems in your family of origin?	Yes	No
Have there been any substance use or abuse issues in your family?	Yes	No
Briefly describe your relationship to your parents:		
Briefly describe your relationship to members of your current household:		
Briefly describe your temperament:		