DARBOUZE, LLC *Phone: 856-200-3522/ Fax: 856-242-2955*
Email: dbhsoutpatient@outlook.com Website: darbouzebh.com

Date: ____________ **Time:** ____________

Welcome to Darbouze, LLC. Before your first date, we would like to know a few things about you and your concerns. Please complete this form in a clear and complete manner. The information in this form will be handled in a strictly confidential manner and will be used by your therapist to provide you with the best possible help.

Patient Information:

First Name: ________________________ **MI:** _____ **Last Name:** _________________________________

Date of Birth: _________________________ **Age:** ______________ **SSN:** ___________________________

Address: ____

Sex: ____**Male** ____**Female** ____ **Transgender** ____**Other (Identity)**______________________________

House number: ___________________________ **Cell number:** __________________________________

Primary Doctor: ___________________________ **Phone Number:** ________________________________

In case of emergency, whom shall we call?

____

Insurance Information:

MEMBER ID: ____

Name of Insurance: ____

Referred by (if any): ____

Reason for Visit: ____

Previous Therapy Information:

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

☐ No

☐ Yes, previous therapist/practitioner: ____

Thank you for choosing Darbouze, LLC

255 Broad Street, Bloomfield, NJ 07003 (North Jersey) The Presidential Center, 101 Route 130 South, Madison Building, Suite 300, Cinnaminson, NJ 08077 (South Jersey)

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Medication Information:

Have you previously received any type of medication/psychiatric medications (ant-anxiety medications, antidepressants, stimulant)?

☐ No

☐ If yes, which? ____

Current Symptoms (Check All That Apply)

☐ Anxiety
☐ Avoidance
☐ Crying Spells
☐ Depression
☐ Suicidal Thoughts
☐ Other: ________________

☐ Panic Attack
☐ Sleep Changes
☐ Excessive Energy
☐ Guilt
☐ Irritability
☐ Other: ________________

☐ Lack of Interest
☐ Risky Activity
☐ Hallucinations
☐ Homicidal Thoughts

What kind of services are you seeking?

_____ Individual Counseling
_____ Couples Counseling
_____ Group/Family counseling
_____ Evaluation/Intake

_____Grief problem solving
_____Required letter/documentation
_____ Alcohol/Drug assessment
______Other (specify): __________________

For each question below, choose the best answer for how you felt over the past week.

1. Are you satisfied with your life?	YES / NO
2. Have you dropped many of your activities and interests?	YES / NO
3. Do you feel that your life is empty?	YES / NO
4. Do you often get bored?	YES / NO
5. Are you in good spirits most of the time?	YES / NO
6. Do you feel happy most of the time?	YES / NO
7. Do you often feel helpless?	YES / NO
8. Do you feel full of energy?	YES / NO
9. Do you think most people are better off than you are?	YES / NO

I certify that all information provided in this application as well as information provided through other means to Darbouze, LLC, is true and complete.

____

Patient's Signature (If 18 years or older) Date