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PATIENT INFORMATION

Name: _____ **Gender:** M F **Date of Birth:** _____

Home Address: _____ **City/State/Zip:**

Occupation: _____ **Employer:** _____

You Are: married divorced separated unmarried **Spouse/Partner's Name:** _____

Phone Contacts: Please indicate the best times to reach you:

Cell: _____ **Home:** _____

Work: _____ **Other:** _____

Email: _____ **Do I have permission to contact you via email?** Yes No

Emergency Contact:
Name: _____

Emergency Contact:
Number: _____

INSURANCE INFORMATION

PRIMARY INSURANCE
Insured's Name: _____
(Last, First, MI)

DOB: _____

Relationship to Patient: _____

Employer: _____

Employer's Address: _____
_____

Insurance Company: _____

ID#: _____

Group #: _____

Plan Name: _____

Phone: _____

SECONDARY INSURANCE
Insured's Name: _____
(Last, First, MI)

DOB: _____

Relationship to Patient: _____

Employer: _____

Employer's Address: _____
_____

Insurance Company: _____

ID#: _____

Group #: _____

Plan Name: _____

Phone: _____

FINANCIAL AGREEMENT

(To be completed and signed by individual responsible for payment)

Patient name: _____

I _____agree to pay all fees and charges for evaluation and treatment for the person named above.

I agree to pay all charges promptly unless credit arrangements are agreed upon in advance. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date.

NOTICE: You are entitled to a copy of this agreement.

Signature: _____ Date: _____

Person Responsible for Payment

Bill to address: _____

Message Phone Number: _____

PERSONAL INFORMATION

Where were you born/raised?

Are there any special circumstances related to your childhood? (adoption, separation, divorce, etc)

Were you raised with any particular religious or cultural beliefs?

What are your current relationship like with your family of origin?

Is there any family history of mental health or substance abuse issues?

CURRENT HOUSEHOLD:		
NAME	**RELATIONSHIP**	**AGE**

Do you have any children not living with you? If yes, please list their names, ages, and where living:

How would you describe your social and relationship history? (active, isolated, etc.)

Who do you consider to be your primary support right now?

RELATIONSHIP STATUS: Single Involved Engaged Cohabitating Married Separated Divorced Widowed

Please make any relevant comments about your current relationship:

PHYSICAL & MENTAL HEALTH HISTORY

Please list all current health care providers:

Current medical (non-psychiatric) illnesses, problems, issues, including allergies. Please be as complete as possible:

Previous medical illnesses, problems, and surgeries (include dates):

Alcohol/Drug/Tobacco/Caffeine use:

Past: _____

Present: _____

Do you have any history of substance abuse problems? (excessive use, dependency, etc.)

Height: _____ **Weight:** _____ **Are you satisfied with your weight?** YES NO

MENTAL HEALTH HISTORY
Have you had mental health problems in the past (please explain)?

Have you sought treatment for this or other mental health problems? Was it helpful?

Were you ever hospitalized for psychiatric reasons? If so, when and where?

Current Medications: Include all medications, psychiatric medications, vitamins, supplements, and over-the-counter drugs.

Medication	Dosage & When Taken (am, pm)	Reason for Taking

Is there anything else I should know about your physical and mental health?

EDUCATION & EMPLOYMENT HISTORY

EDUCATIONAL INSTITUTION	DATES	COURSE OF STUDY	Diploma, Degree, Certificate

Do you have a history of learning problems? If so, please explain:

WORK HISTORY:

EMPLOYER	POSITION	DATES	REASON FOR LEAVING

Do you have a history of problems in the workplace? If yes, please explain?

Do you have difficulty maintaining employment? If so, why?

Is there anything else you would like me to know about your education and/or work history?

SYMPTOM CHECKLIST:

☐ Chronic sadness	☐ Sick Often
☐ Crying episodes	☐ Chest Pain
☐ Hopelessness	☐ Muscle Tension
☐ Irritability	☐ Headaches
☐ Mood Swings	☐ Stress
☐ Elevated Mood	☐ Fatigue and/or Low Energy
☐ Low Frustration Tolerance	☐ Dizziness
☐ Feeling Worthless	☐ Physical Pain
☐ Low Self-Esteem	☐ Heart Palpitations
☐ Sleep Problems and/or Nightmares	☐ Work Difficulties
☐ Change in Appetite and/or Weight	☐ Withdrawing from Others
☐ Suicidal Thoughts	☐ Impulsiveness
☐ Thoughts of Harming Others	☐ Social/Family Conflicts
☐ Anger Perfectionism	☐ Loneliness/Isolation
☐ Anxiety/Nervousness	☐ Poor Judgment
☐ Worrying	☐ Hallucinations
☐ Intrusive Thoughts	☐ Easily Distracted
☐ Body Image Concerns	☐ Difficulty Concentrating
☐ Panic Attacks	☐ Memory Problems
☐ Eating Behavior Issues	☐ Other: _____
☐ Violent Behavior	☐ Other: _____

What are your strengths?

Please provide a brief description of why you are seeking services at this time:

Thank you for taking the time to complete this form!