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Please thoroughly complete these forms.
The more information you give me, the better I can help you.

Name of patient _____ Date _____

Date of birth _____ Age _____

Home address _____ / _____
Street address Apartment #

_____ / _____ / _____
City State Zip code

Cell phone _____ Home phone _____ Work phone _____

Do I have permission to contact you? Cell phone Home phone Work phone

How did you find out about me? Insurance Psychology Today Website

Referral By whom? _____

Other _____

What is the main reason you are seeking help? _____

Gender: M F Other _____

Sexual pref.: Heterosexual Homosexual Bisexual Other _____

Adopted: Yes No

Married (# of Times _____) Separated Divorced Widowed

Cohabiting Domestic partnership Never married - not living with a partner

Religious preference _____ Practicing? Yes No

Occupation _____ Employer _____

Problems at work Conflict with another employee Other work problems

If college student, school _____ Year in school _____

Declared Major _____

Highest grade completed: High school Some college Associates degree

Four year degree Post graduate Doctorate Medical

Have you ever been in the military? Yes No Branch? _____

Type of discharge _____

Have you ever had mental health counseling before? Yes No

Have you ever been in a psychiatric hospital? Yes No

Are you taking any psychiatric medication Yes No

List medicine(s) _____

Have you ever had drug/alcohol counseling? Yes No

Have you ever been in a drug or alcohol inpatient facility? Yes No

List program(s) _____

Do you have any medical problems? Yes No

List problem(s) _____

Do you have any legal problems, including being sued for divorce? Yes No

Have you ever been arrested, include DUI? Yes No

Comments _____

How often in the past month did you drink alcohol? Not at All About Once a Month

2-3 Times a Month 2-3 Times a Week Once a Day or More

Comments _____

How often in the past month did you smoke cigarettes? Not at All About Once a Month

2-3 Times a Month 2-3 Times a Week Once a Day or More

Comments _____

How often in the past month did you smoke pot? Not at all About Once a Week

2-3 Times a Month 2-3 Times a Week Once a Day or More

Comments _____

How often in the past month did you take pain medicine? Not at All About Once a Month

2-3 Times a Month 2-3 Times a Week Once a Day or More

Comments _____

How often in the past month did use a sleep aide? Not at All About Once a Month

2-3 Times a Month 2-3 Times a Week Once a Day or More

Comments _____

Do you participate in regular exercise? Not at All About Once a Month 2-3 Times a Mo

2-3 Times a Week Once a Day or More

Comments _____

Biology Counts!

Please Answer These Questions About Biological Relatives
According To Your *Opinion*:

Have any biological relatives had learning difficulties? Yes No

Who? _____

Are any biological relatives intellectually gifted? Yes No

Who? _____

Any biological relatives have a major illness? Yes No

Who? _____

Do any biological relatives have depression or sadness? Yes No

Who? _____

Do any biological relatives have anxiety, panic or worry? Yes No

Who? _____

Do any biological relatives have problems with their anger? Yes No

Who? _____

Do any biological relatives drink too much? Yes No

Who? _____

Do any biological relatives have problems with drugs, prescription or otherwise? Yes No

Who? _____

Are any biological relatives in recovery from drug or alcohol abuse? Yes No

Who? _____

Have any biological relatives ever been incarcerated? Yes No

Who? _____

Please add anything you want to mention: _____

Fill Out for Children 17 years and Younger

Developmental History

Was the pregnancy 9 months? Yes No

Any Birth Complications? Yes No

List _____

Has the child ever lost consciousness? Yes No

Does the child have any medical problems? Yes No

List _____

School History

School child attends _____ Grade? _____

Does the child have an IEP? Yes No

If Yes, What grade did the IEP start? _____

Is the child in gifted or honors classes? Yes No

Is the child a school disciplinary problem? Yes No

Is the child failing or in danger of failing? Yes No

Does the child frequently visit the nurse's office? Yes No

Other Interests

Is the child involved in any athletics? Yes No

List _____

Does the child play an instrument? Yes No

List _____

Is the child involved in any religious sponsored activities? Yes No

List _____

Does the child have any special talents? Yes No

List _____

What are the child's strengths? _____

What are the child's weaknesses? _____

Fill Out for Children 17 years and Younger

Please Check All That Apply

- | | |
|--|--|
| <input type="checkbox"/> Losing weight | <input type="checkbox"/> Defiant |
| <input type="checkbox"/> Leader | <input type="checkbox"/> Has a job |
| <input type="checkbox"/> Neglecting hygiene | <input type="checkbox"/> Has a girl/boyfriend |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Drinks alcohol |
| <input type="checkbox"/> Change of friends | <input type="checkbox"/> Uses birth control |
| <input type="checkbox"/> Stopped playing sports | <input type="checkbox"/> Has a driver's license |
| <input type="checkbox"/> Crying | <input type="checkbox"/> Uses drugs |
| <input type="checkbox"/> Isolating in room | <input type="checkbox"/> Has had sex |
| <input type="checkbox"/> Breaks house rules | <input type="checkbox"/> Follower |
| <input type="checkbox"/> Destroys property | <input type="checkbox"/> Gaining weight |
| <input type="checkbox"/> Never home | <input type="checkbox"/> Worries |
| <input type="checkbox"/> Has fears | <input type="checkbox"/> Shy |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Disrespectful to adults |
| <input type="checkbox"/> Has friends | <input type="checkbox"/> Gets teased |
| <input type="checkbox"/> Doesn't sit still | <input type="checkbox"/> Unorganized |
| <input type="checkbox"/> Problems concentrating | <input type="checkbox"/> Poor grades |
| <input type="checkbox"/> Cuts their body | <input type="checkbox"/> Illnesses |
| <input type="checkbox"/> Frequent visits to the school nurse | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Athletic | <input type="checkbox"/> Argues |
| <input type="checkbox"/> Smokes cigarettes | <input type="checkbox"/> Had nonconsensual sex |

Other _____

Informed Consent

The practice of psychotherapy focuses on a broad range of issues over a period of time and helps uncover patterns of thinking and interacting that are contributing to distress. Psychotherapy applies principles of human development through cognitive, affective and behavioral intervention strategies that enhance wellness and personal growth and reduce pathology.

Benefits of Psychotherapy

Research indicates that most people benefit from psychotherapy. “Talk therapy” allows people to learn about themselves and improve their relationships, productivity and reduce stress and impaired functioning.

Risks of Psychotherapy

During the psychotherapy process, you may experience strong feelings like anger or sadness or remember difficult events. In addition, changes you make may disrupt relationships with the people around you. I will support and assist you with any distress incurred during treatment.

Signing below signifies that you have read and understand the benefits and risks of psychotherapy and consent to treatment.

Print Patients Name

Signature

Date

Print Parent / Guardian Name

Signature

Date

Cancellations and Financial Responsibility

Cancellations

Office appointments are held exclusively for you. You are required to give “day before” notice of cancellation of an appointment. You can notify me by contacting my office or sending me a text. Failure to give “day before” notice will incur an office charge at the full office rate. Emergency cancellations are assessed case by case.

Financial Responsibility

I agree to be responsible for all office fees billed at the current office rate and agreed upon ancillary fees such as report writing or accompanying you to a meeting, etc. In addition, if my insurance carrier denies a claim for ANY reason; including exhausting of benefits, failure to secure an authorization or meet a deductible, I will be responsible for payment of any unpaid services.

Print Patients Name

Signature

Date

Print Parent / Guardian Name

Signature

Date

Confidentiality & Privacy Policy

The law protects the relationship between a client and a psychotherapist, and information cannot be disclosed without written permission.

Exceptions include:

- If a client intends cause harm to himself or herself, I will make every effort to enlist their cooperation in ensuring their safety. If they do not cooperate, I will take further measures without their permission that are provided to me by law in order to ensure their safety.
- If a client is threatening serious bodily harm to another person/s, I must notify the police and inform the intended victim.
- If there is suspected child abuse or dependent adult or elder abuse, for which I am required by law to report this to the appropriate authorities immediately.

Print Patients Name

Signature

Date

Print Parent / Guardian Name

Signature

Date

Insurance Information

Name of insurance company _____

Policy ID number _____

Behavioral health phone number (back of card) _____

Patient name _____ Date of birth _____

Patient address _____

Patient phone () _____

Patient relationship to policy holder: Self Spouse Child Other

(Skip the following policy holder questions if patient is the policy holder)

Policy holder name _____ Date of birth _____

Policy holder address (same as patient)

Policy holder phone () _____

Signature of person filling out this information

Date

Credit Card Payments and Policies

In helping to keep administrative costs down, the responsible financial party is expected to provide a valid credit card. Credit card transactions can be used at any time and will be charged a 4% handling fee.

Full name of credit card holder _____

Credit card (circle one): Visa Master Card AmEx Discover

Credit card number _____

Credit card expiration date _____

Credit card 3 or 4 digit security code _____

Credit card billing address:

House/Street Number Apt./Unit Street Name Zip Code

Outstanding balances that are not paid within 30 days of billing will automatically be charged to the credit card. Unpaid therapy sessions will be charged at the **current office rate** plus 4% handling fee. Unpaid returned check fees are \$35 plus a 4% handling fee.

I understand and agree to the terms of credit card use.

Signature

Date