Lori Weiniger, MSW, LCSW

106 S. Bellevue Ave., Ste. 209, Langhorne, PA 19047

Phone/Fax (215) 750-1320 –♦– straighttalkwithlori@gmail.com

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

☐ Cohabitating ☐ 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: ______________________________
____
____
____

For Patients 18 Years and Older

Please Check All That Apply

- ☐ Losing weight
- ☐ Sad
- ☐ Loss of time from work
- ☐ No appetite
- ☐ Nervous
- ☐ Pushing/hitting in home
- ☐ Adult children live home
- ☐ Problems concentrating
- ☐ Caring for sick relative
- ☐ Drug/alcohol abuse in home
- ☐ Nightmares
- ☐ Gaining weight
- ☐ Worries
- ☐ Work stress
- ☐ Relationship problems
- ☐ Concern about someone's drinking
- ☐ Concern about someone's drug use
- ☐ Recent death -
- ☐ Loss of motivation
- ☐ Angry
- ☐ Financial problems
- ☐ Shy
- ☐ Tired
- ☐ Irritable
- ☐ Sleep problems
- ☐ Fears
- ☐ Marital problems
- ☐ On disability
- ☐ Employed
- ☐ Depressed
- ☐ Medical problems
- ☐ Anxiety
- ☐ Family stress
- ☐ Unemployed
- ☐ Guilt
- ☐ Sexual problems
- ☐ Suicidal thoughts
- ☐ Headaches

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