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Print Form

This is an electronically fillable form. You can type or click directly into each field.

Please do your best to answer all questions. This information will be used in your first session as a starting point for discussion and help me design a treatment plan specifically for your needs. When finished completing the form, you need to return to the top right hand corner of this page and click on the 'Print Form' button. You will bring this completed and printed form with you to the first appointment and sign and date it at that time. Please print a second copy for your records.

Full Legal Name: Date of Birth:

Spouse/Partner's Name: Date of Birth:

Home Address:

Phone: (Home) (Cell) (Work)

Is it ok to leave a message at one of the above numbers? ◯ **Yes** ◯ **No**

Email Adress:

Is your email address confidential? ◯ **Yes** ◯ **No**

Marital/Relationship Status:

Profession & Employment Status:

Educational Background:

Children (*include biological, adopted, foster, & step*):

Name	Sex	DOB	Type (B/A/F/S)	Custody (Y/N)
	◯ **M** ◯ **F**			◯ **Yes** ◯ **No**
	◯ **M** ◯ **F**			◯ **Yes** ◯ **No**
	◯ **M** ◯ **F**			◯ **Yes** ◯ **No**
	◯ **M** ◯ **F**			◯ **Yes** ◯ **No**
	◯ **M** ◯ **F**			◯ **Yes** ◯ **No**

Are you presently under a physician's care? ◯ **Yes** ◯ **No**

If yes, what for?

Name & Address of Physician:

Person to contact in case of emergency:

Name:

Phone: (Home) (Cell) (Work)

Email:

Primary Insurance Information

Name of Insurance Holder (Insured):

Insured SSN: Insured Birth Date:

Employer: Payor/Health Plan:

Patient's Relationship to the Insured:

Member #: Policy/Group #:

Insurance Co. Contact Phone Number:

Family History

Are your parents still living? **Father:** ◯ **Yes** ◯ **No** **Mother:** ◯ **Yes** ◯ **No**

Do you have brothers and/or sisters? ◯ **Yes** ◯ **No**

If 'yes', how many and what is the birth order?

Personal Medical History

Do you have any allergies to food and/or medications?

If yes, please describe:

Please list any prescription medications you currently use (Include name,dosage, frequency):

Please List any over-the-counter medications you currently use such as vitamins, sleeping/diet pills, aspirin/pain relievers, etc. (Include name, dosage, frequency):

Please list hospitalizations from past medical/surgical illnesses (Include name of hospital, dates of confinement, illness/procedure):

When was your last physical examination done? (Include date & doctor's name):

Were there any significant findings?

When was your last blood test?

When was your last EKG?

Are you currently being treated for any medical conditions: ◯ **Yes** ◯ **No**

If yes, please list:

Do you experience any of the following? (Please check all responses that apply)

- ☐ Double or poor vision
- ☐ Difficulty hearing
- ☐ Fainting
- ☐ Blackouts
- ☐ Convulsions
- ☐ Paralysis
- ☐ Unusual excessive thirst/dry mouth
- ☐ Indigestion, gas, heartburn
- ☐ Stomach pain
- ☐ Diarrhea or constipation
- ☐ Vomiting/vomiting blood
- ☐ Blood in stool

- ☐ Dizziness
- ☐ Headaches
- ☐ Thyroid problem
- ☐ Cough or wheezing
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Palpitations
- ☐ Swelling of hands or feet
- ☐ Change in appetite or eating habits
- ☐ Trouble Sleeping
- ☐ Sexual problems
- ☐ Problems with memory, thinking, concentration or attention
- ☐ Weakness or tiredness
- ☐ Joint pain
- ☐ Lumps anywhere on body – Please specify location: _____
- ☐ Weight gain or loss: ◯ **gain** ◯ **loss**

pounds: _____ Time period: _____

Have you ever used drugs or alcohol? ◯ **Yes** ◯ **No**

If yes, please describe:

Substance	**Amount**	**Frequency**	**Last Taken**

Do you have a history of blackouts, seizures or withdrawal symptoms? ◯ **Yes** ◯ **No**

If yes, please describe: _____

Have you ever received mental health or substance abuse treatment before? ◯ **Yes** ◯ **No**

If yes, please describe (If applicable, please list name of medication and dosage taken for condition):

Type of Treatment (inpatient/outpatient)	**Provider**	**First Seen**	**Last Seen**

Are there any compulsive/repetitive behaviors or thoughts that are of concern to you and/or the people close to you? (i.e. gambling, spending, sexual behavior, use of food, exercise, television watching, hoarding, checking, counting, washing, illness-related, thought of harming someone, use or fear of use of obscene language,etc.)? ◯ **Yes** ◯ **No**

If yes, please describe:

Have you ever been arrested for a crime? ◯ **Yes** ◯ **No**

If yes, please describe:

Lifestyle/Habits

	Amount currently using	Most ever used	When/how long ago?
Coffee (cups/day)			
Caffeinated soft drinks			
Cigarettes (pack/day)			
Alcohol (drinks/day)			
Cigars/pipes (per day)			
Marijuana			
Prescription Medication			

Please describe your reason(s) for seeking treatment at this time (include date or month/year the problem started):

Was there an event which made these issues or problems surface: ◯ **Yes** ◯ **No**

If yes, please describe:

What results do you expect from treatment?

Please indicate and rate the severity (1-4) of the following issues or problems you would like to work on in treatment.

NO PROBLEM 1	MILD PROBLEM 2	MODERATE PROBLEM 3	SEVERE PROBLEM 4
____ Depression	____ Lack of friends	____ Marriage/Relationship issues	
____ Anxiety	____ Loneliness	____ Sexuality/Sexual issues	
____ Controlling stress	____ Problems coping	____ Family conflict	
____ Loss of a loved one	____ Abused victimization	____ Behavioral problems	
____ Problems at school	____ Financial problems	____ Eliminating a drug/alcohol habit	
____ Problems at work	____ Legal matters	____ Eliminating another habit	
____ Other (please specify):			

Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect	Not Applicable
Marriage/Relationship	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
Family	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
Job/School performance	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
Friendships	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
Financial situation	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
Physical health	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
Anxiety level/Nerves	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
Mood	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
Eating habits	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
Sleeping habits	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
Sexual Functioning	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6

	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect	Not Applicable
Ability to concentrate	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
Ability to control temper	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6
Spirituality	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6

TOTAL:

	Type(s)	Frequency
Current Exercise		

Current Hobbies

Hours/week spent at work:

Family Medical History

A. Has anyone in your family had a serious medical illness? ◯ **Yes** ◯ **No**

If 'yes' please explain:

B. Has anyone in your family had a psychiatric (nervous or mental) illness? ◯ **Yes** ◯ **No**

If yes, please explain:

C. If yes, what type of treatment, if any, did they receive?

D. May I contact and exchange information with your primary care physician to coordinate Care? ◯ **Yes** ◯ **No**

E. What do you consider to be your most significant strengths?

Thank you for providing me with an account of your health and well-being. This information will help me design a treatment plan geared specifically to your individual needs. Please feel free to discuss any aspect of your answers with me.

PLEASE PRINT THIS DOCUMENT BY RETURNING TO PAGE 1 AND CLICKING ON THE "PRINT FORM" BUTTON. YOU WILL BRING A COPY TO YOUR FIRST APPOINTMENT AND SIGN AND DATE IT AT THAT TIME. PRINT A SECOND COPY FOR YOUR RECORDS.

I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize release of any information, including that related to psychiatric, drug and alcohol, or HIV related issues, necessary to secure payment of benefits from insurance company or other payor and for case review and quality improvement procedures. I give permission for the treatment of the above minor if applicable.

I also request that insurance benefits be assigned to: _____

Signature: _____ **Date:** _____