



PROFESSIONAL PSYCHOLOGICAL SERVICES, P.C.

Please Print Clearly.

PATIENT'S NAME _____ DOB _____ AGE _____ SEX _____

Street

City

Zip Code

SINGLE

MARRIED

SEPARATED

WIDOW(ER)ED

DIVORCED

HOME PHONE _____ OCCUPATION _____

EMPLOYED BY _____ PHONE _____

SPOUSE'S NAME _____ OCCUPATION _____

EMPLOYED BY _____ PHONE _____

HOW YOU LEARNED OF PRACTICE _____ MEDICAL INSURANCE: YES NO

YOUR SOCIAL SECURITY # _____ DRIVERS LICENSE # _____

PERSON TO CONTACT IN EMERGENCY _____

ADDRESS _____ PHONE _____

CREDIT CARD AUTHORIZATION

If you wish Professional Psychological Services to file for direct reimbursement by your insurance company or if you prefer your charges to be made to your bank card account, please provide information requested below. Your signature will be your authorization to Professional Psychological Services to charge your credit account for any balance not payable by insurance benefits. You will be notified of any charge made to your account. If your account should be overpaid you will be informed and a reimbursement will be made to you at your request.

CREDIT LINE: MasterCard Visa American Express Discover

Account Number: _____

Card Expiration Date: _____

Name Appearing on Account: _____

Signature: _____



PROFESSIONAL PSYCHOLOGICAL SERVICES, P.C.

CONSENT TO COMMUNICATE WITH REFERRAL SOURCE

IF YOU CONSENT TO ALLOW YOUR THERAPIST, _____, TO COMMUNICATE WITH YOUR REFERRING PHYSICIAN, THERAPIST, OR ATTORNEY REGARDING YOUR CASE PLEASE SIGN BELOW. YOUR SIGNATURE WILL INDICATE YOUR CONSENT UNTIL THIS OFFICE IS GIVEN WRITTEN NOTICE THAT YOU ARE WITHDRAWING YOUR CONSENT.

_____	(_____)_____
Physician/Therapist/Attorney Name	Telephone
_____	_____
Signature	Date of Signature

ASSIGNMENT OF INSURANCE BENEFITS

(Do not provide insurance information if you do not want our office to file your claims with your insurance company.)

I hereby assign payment of medical benefits by

Insurance company		

Insured's Name	Insured's Date of Birth	
SOCIAL SECURITY # _____	I.D. # _____	GROUP # _____

to Professional Psychological Services, P.C. I also authorize the release of any medical information requested by the above named insurance or managed health care company to the extent allowed by law. The assignment will remain in effect until revoked by me in writing, a photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance company except to the extent that a contract between the provider and a managed health care company might limit that financial responsibility.

Date

Signature

Instructions: To assist us in helping you, please fill out the following pages as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to you, leave them blank.

Medical History

Name and address of your primary physician:

Physician's name: _____

Address: _____

List any major illnesses and/or operations you have had: _____

Have you ever experienced a head injury which resulted in loss of consciousness? Yes No

Have you ever had a seizure? Yes No

List any physical concerns you are having at present: (e.g., high blood pressure, headaches, dizziness, etc.):

List any other physical concerns you have experienced in the past: _____

When was your most recent complete physical exam? _____

Results of physical exam: _____

On average how many hours of sleep do you get daily? _____

Do you have trouble falling asleep at night? No Yes If Yes, describe _____

Have you gained/lost over ten pounds in the past year? Yes No _____ lbs gained _____ lbs lost

If Yes, was the gain/loss on purpose? Yes No

Describe your appetite (during the past week):

_____ poor appetite _____ average appetite _____ large appetite

What medications (and dosages), including "over-the-counter" medications and herbal or sports supplements, are you taking at present, and for what purpose? (Use opposite side of page, if necessary.)

Medication

Purpose

_____	_____
_____	_____
_____	_____
_____	_____

Which of the following have you consumed in the last six months?

Alcohol Yes No If yes, how much and how often? _____

Nicotine Yes No If yes, how much and how often? _____

Other Drugs Yes No If yes, what, how much, and how often? _____
often? _____

Family History

Mother's age: _____ If deceased, how old were you when she died?: _____

Father's age: _____ If deceased, how old were you when he died?: _____

If your parents are separated or divorced, how old were you then? _____

Number of brother(s) _____ Their ages _____ _____ _____ _____ _____

Number of sister(s) _____ Their ages _____ _____ _____ _____ _____

I was child number _____ in a family of _____ children.

Were you adopted or raised with parents other than your natural parents? Yes___ No ___

Thoughts and Behaviors

Please check how often the following thoughts occur to you:

- | | | | | |
|--------------------------------|----------|-----------|--------------|---------------|
| 1) Life is hopeless. | ___Never | ___Rarely | ___Sometimes | ___Frequently |
| 2) I am lonely. | ___Never | ___Rarely | ___Sometimes | ___Frequently |
| 3) No one cares about me. | ___Never | ___Rarely | ___Sometimes | ___Frequently |
| 4) I am a failure. | ___Never | ___Rarely | ___Sometimes | ___Frequently |
| | | | | |
| 5) Most people don't like me. | ___Never | ___Rarely | ___Sometimes | ___Frequently |
| 6) I want to die. | ___Never | ___Rarely | ___Sometimes | ___Frequently |
| 7) I want to hurt someone. | ___Never | ___Rarely | ___Sometimes | ___Frequently |
| 8) I am so stupid. | ___Never | ___Rarely | ___Sometimes | ___Frequently |
| | | | | |
| 9) I am going crazy. | ___Never | ___Rarely | ___Sometimes | ___Frequently |
| 10) I can't concentrate. | ___Never | ___Rarely | ___Sometimes | ___Frequently |
| 11) I am so depressed. | ___Never | ___Rarely | ___Sometimes | ___Frequently |
| 12) God is disappointed in me. | ___Never | ___Rarely | ___Sometimes | ___Frequently |
| | | | | |
| 13) I can't be forgiven. | ___Never | ___Rarely | ___Sometimes | ___Frequently |
| 14) Why am I so different? | ___Never | ___Rarely | ___Sometimes | ___Frequently |
| 15) I can't do anything right. | ___Never | ___Rarely | ___Sometimes | ___Frequently |
| 16) People hear my thoughts. | ___Never | ___Rarely | ___Sometimes | ___Frequently |
| | | | | |
| 17) I have no emotions. | ___Never | ___Rarely | ___Sometimes | ___Frequently |
| 18) Someone is watching me. | ___Never | ___Rarely | ___Sometimes | ___Frequently |
| 19) I hear voices in my head. | ___Never | ___Rarely | ___Sometimes | ___Frequently |
| 20) I am out of control. | ___Never | ___Rarely | ___Sometimes | ___Frequently |

Please comment (e.g., examples, frequency, duration, effects on you) about each of the above thoughts that occur frequently or are a concern to you. Use the back of this sheet if necessary.
