

PATIENT PERSONAL HEALTH INFORMATION

Please Print Clearly. Complete all pages.

Patient's Name _____ DOB _____ Age _____ Sex _____

Street City Zip Code

SINGLE MARRIED SEPARATED WIDOW(ER)ED DIVORCED

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____

Spouse's Name _____ Occupation _____

Employed by _____ Work Phone _____

Learned of Practice by _____ MEDICAL INSURANCE: YES NO

Social Security # _____ - _____ - _____ Drivers License # _____

Person to Contact in Emergency _____

Address _____ Phone _____ 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 Discover (Circle one)

Account Number: _____

Card Expiration Date: _____ (3 digit security code _____)

Name Appearing on Account: _____

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 #1

Insured's Name

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. I understand that such information may include information identifying myself and the insurance holder, as well as my symptoms, general functioning, diagnosis, and general supportive data. The assignment and release will remain in effect, but may be revoked by me in writing, at any time except to the extent that action has previously been taken thereupon. 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

**CONSENT AND AUTHORIZATION FOR THERAPIST
TO COMMUNICATE WITH PRIMARY CARE PHYSICIAN**

If you consent to allow your therapist, _____, to communicate with your primary care physician regarding your case please sign below. Your signature will indicate your consent and authorization until this office is given notice that you are withdrawing your consent and authorization for communication.

Name of Primary Care Physician

(_____)

Telephone

Physician's Address

Your 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, please indicate so.

What are the main problems or concerns that cause you to be here at this time? _____

Medical/Psychological History

Name and address of your primary physician:

Physician's name: _____

Address: _____

List any major illnesses, injuries, and/or operations you have had throughout your life _____

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.)

<u>Medication</u>	<u>Purpose</u>	<u>Dose</u>	<u>When Started</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been treated for stress or "nervous" disorders? Yes No

If yes, what were you treated for and what was the nature of the treatment? _____

Have you previously been seen for counseling or therapy as an adult or when you were a child

(either individually or with someone else)? Yes No

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? _____

Have you or others ever been concerned about your alcohol or other substance use? Yes No

Have you ever experienced any legal consequences due to alcohol or drug use/possession? Yes No

Are you presently concerned about your alcohol or other substance use? Yes No

If yes, what are your concerns and how serious are they? _____

Have you ever been the victim of violence or experienced traumatic events? _____

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 raised with living with both biological parents? Yes No

Have family members (including grandparents) had problems with alcohol or drugs? Yes No

If so, who, and what was the nature of the problems they experienced? _____

Have any family members had problems with depression or anxiety?

Have any family been treated for psychological disorders or "nervous" conditions? Yes No

If yes, who and for what were they treated? _____

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.

Symptoms

Check the behaviors and symptoms that occur to you more often than you would like them to take place:

<input type="checkbox"/> aggression	<input type="checkbox"/> fatigue	<input type="checkbox"/> sexual difficulties
<input type="checkbox"/> alcohol dependence	<input type="checkbox"/> hallucinations	<input type="checkbox"/> sick often
<input type="checkbox"/> anger	<input type="checkbox"/> heart palpitations	<input type="checkbox"/> sleeping problems
<input type="checkbox"/> antisocial behavior	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> speech problems
<input type="checkbox"/> anxiety	<input type="checkbox"/> hopelessness	<input type="checkbox"/> suicidal thoughts
<input type="checkbox"/> avoiding people	<input type="checkbox"/> impulsivity	<input type="checkbox"/> thoughts disorganized
<input type="checkbox"/> chest pain	<input type="checkbox"/> irritability	<input type="checkbox"/> trembling
<input type="checkbox"/> depression	<input type="checkbox"/> judgment errors	<input type="checkbox"/> withdrawing
<input type="checkbox"/> disorientation	<input type="checkbox"/> loneliness	<input type="checkbox"/> worrying
<input type="checkbox"/> distractibility	<input type="checkbox"/> memory impairment	<input type="checkbox"/> other (specify)
<input type="checkbox"/> dizziness	<input type="checkbox"/> mood shifts	_____
<input type="checkbox"/> drug dependence	<input type="checkbox"/> panic attacks	_____
<input type="checkbox"/> eating disorder	<input type="checkbox"/> phobias/fears	_____
<input type="checkbox"/> elevated mood	<input type="checkbox"/> recurring thoughts	_____

Please give examples of how each of the symptoms that you checked impairs your ability to function (e.g., socially, emotionally, occupationally, physically, etc.). Use the back of this sheet if necessary.

PLEASE BRING THIS AND OTHER ASSESSMENT MATERIALS TO THIS OFFICE AT THE TIME OF YOUR APPOINTMENT. OTHERWISE, YOU WILL NEED TO COMPLETE THE PAPERWORK AGAIN PRIOR TO YOUR APPOINTMENT.