For Office Use:
Therapist:_____
Dx:_____ Today's Date:_____

(PLEASE PRINT)

PATIENT INFORMATION QUESTIONNAIRE

Patient Name:_____ Age: ____ Birthdate:_____
Last Name First Name Middle
Patient S.S.#:_____ Driver's License #:_____
Address:_____
City:_____State:_____Zip Code:_____
Phone: Home ( )_____Work ( )_____Cell ( )_____
___Ok to leave msg? ___Ok to leave msg? ___Ok to leave msg?

E-mail: _____
□ Check here if we can email you about general practice information, groups, seminars, workshops, and satisfaction surveys. (We will not release email address to 3rd parties)

Marital Status:_____Occupation:_____Education:_____

Others who have authority to discuss insurance and payment/billing issues with our staff (Names, Relationships): _____

If patient is a child:

Parent/Guardian 1:_____
Address:_____
_____
Phone (H)_____(W)_____
Occupation:_____

Parent/Guardian 2:_____
Address:_____
_____
Phone (H)_____(W)_____
Occupation:_____

All patients:

Who else lives in the home? Please list ages._____
_____
Emergency contact: Name:_____Relationship:_____Phone:_____
Address:_____
Who referred you to us?_____Address:_____
Who is your (or your child's) physician?_____
Address:_____Phone:_____
When was your (or your child's) last physical?_____
Briefly describe your reasons for seeking help._____
_____
_____
List any major health problem(s)._____
_____
List any medications you (or your child) are currently taking._____
_____
List any allergies to medications._____
Have you (or your child) ever received psychiatric or psychological help or counseling of any kind before?_____If yes, name of therapist(s):_____
Approximate dates:_____Type of problem(s):_____

PLEASE COMPLETE SIDE TWO

Please circle any of the following problem(s) that pertain to you (adult).

nervousness	depression	fears	shyness
separation/divorce	sexual problems	abuse/domestic violence	finances
suicidal thoughts	drug use	alcohol use	friends
anger	self-control	hearing voices	sleep
stress	work	relaxation	headaches
violent thoughts	memory	ambition	legal matters
energy	insomnia	making decisions	loneliness
concentration	inferiority feelings	education	marriage
health problems	temper	nightmares	career choices
children	appetite	stomach trouble	bowel trouble
parenting	my thoughts	sexual identity	tiredness
internet/computer			

If you are seeking help for your child, please circle any of the following problem(s) which concern you.

stealing/lying	tiredness	clumsiness	suicidal thoughts
eating problems	over-activity/hyper	school problems	sex problems
under-activity	running away	shyness	easily upset
toilet problems	fears	self-critical/guilty	temper tantrums
over-dependency	depression	aggression	jealousy/resentment
destructive	sleep problems/nightmares	cruelty	health problems
nervousness	over-sensitive	unusual habits	physical complaints

INSURANCE INFORMATION (MUST BE COMPLETED)

Person responsible for this account:_____Relationship to Patient:_____
Address:_____Phone #:_____
Policyholder's Name:_____Birthdate:_____S.S. #:_____
Employer:_____Address:_____
Insurance Plan:_____Address:_____
I.D. #:_____Group #:_____

If other insurance:
Policyholder's Name:_____Birthdate:_____S.S. #:_____
Employer:_____Address:_____
Insurance Plan:_____Address:_____
I.D. #:_____Group #:_____

Signature On File & Assignment/Release

I authorize use of this form on all my insurance submissions. I further authorize release of information to all my insurance carriers and/or managed care companies. I authorize Psychology and Counseling Associates to act as my agent in helping me obtain payment from my insurance carriers. I understand that I am financially responsible for any non-covered services or unpaid balances. I authorize payment directly to Psychology and Counseling Associates, P.C. I permit a copy of this authorization to be use in place of the original. I verify that the answers to the above questions are true and accurate to the best of my knowledge.

Signature_____Date_____