INFORMATION SHEET

PATIENT INFORMATION

Date: _______________

Name: ________________________________

Address: ________________________________

____

Home Phone: ________________________________

Birthdate: ________________________________

Soc. Sec. #: ________________________________

Employer: ________________________________

School/Grade: ________________________________

Work Phone: ________________________________

Occupation: ________________________________

Relationship to Insured: ________________________________

Marital Status: Married ☐ Sep ☐ Div ☐ Widow ☐ Single ☐ Co-Habit ☐

Emergency Contact: ________________________________

Phone #: ________________________________

PRIMARY INSURANCE INFORMATION

☐ self ☐ parent ☐ spouse ☐ guardian

Name ________________________________
Last First M.I.

Address ________________________________
(if different)

____

Home Phone ________________________________
(if different)

Birthdate ________________________________

Soc. Sec. # ________________________________

Insured's Employer ________________________________

Work Phone (____)________________________________

Insurance Co ________________________________

Plan Name ________________________________

Insured's ID # ________________________________

Policy Group # ________________________________

RESPONSIBLE PARTY/SECONDARY INSURANCE

☐ self ☐ parent ☐ spouse ☐ guardian

Insured's Name ________________________________
Last First M.I.

Address: ________________________________
(if different)

____

Home Phone: ________________________________
(if different)

Birthdate: ________________________________

Soc. Sec. #: ________________________________

Insured's Employer ________________________________

Work Phone (____)________________________________

Insurance Co. ________________________________

Plan Name ________________________________

Insured's ID # ________________________________

Policy Group # ________________________________

Authorization to Release Information: I authorize the release of any medical or other information necessary to process Insurance claims.

____
Signature Date

Authorization to Pay Benefits to Provider: I authorize payment of benefits directly to the therapist for the services provided. Where applicable, I also request payment of government benefits to the party who accepts assignment.

____
Signature Date

PERSONAL INFORMATION

Name:____

Referred by: ____

Previous Counseling/Treatment:

(Who) ________________________ (Where) ________________________ (When) __________

(Results)____

(Who) ________________________ (Where) ________________________ (When) __________

(Results)____

Nature of Current Problems: ____

____

____

____

Others Living in the Home:

Name ______________________ DOB ___/___/___ School/Employer: __________________

Name ______________________ DOB ___/___/___ School/Employer: __________________

Name ______________________ DOB ___/___/___ School/Employer: __________________

Name ______________________ DOB ___/___/___ School/Employer: __________________

MEDICAL INFORMATION

Primary Care Physician: ______________________ Date of Last Visit: ______________

Address: _________________________________ Medical Issues: _________________

Physician's Phone: ___________________________ ___________________________

Allergies: _________________________________ Current Medications: *(Inclued dosage and length of usage)*____

Adverse Reaction to Medications ____

OFFICE USE ONLY

Diagnosis

Date First Seen: ______________________ DSM - IV ICD 9 CM Date

of First Symptom: ___________________ Axis 1 __________ 1. _________

Fee: _________________________________ Axis II __________ 2. _________

_____________________________________ Axis III __________ 3. _________

Axis IV __________ 4. _________

Axis V __________ 5. _________