

Patient Data

Patient Information: Please fill out completely.

Today's Date: _____

Name: _____

Home/Cell Phone: _____ Work phone: _____

Email address: _____

***Please indicate by initialing where we may leave a message and/or send correspondences/handouts:**

Home/Cell _____ Work _____ Email: _____

Address: _____

City _____ State _____ Zip _____

Date of Birth: _____ Sex: Male: _____ Female: _____ Last 4 SS #: _____

Marital Status: Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____

Name of spouse/significant other _____

Children's names and ages _____

Employer: _____ Occupation: _____

Education (Highest degree/level completed) _____

Emergency Contact (this person may be contacted if there is a medical/psychological emergency)

Name: _____ Relationship: _____

Cell phone _____ Home phone _____

Address _____

Health Information

Please rate your health: Very Good _____ Good _____ Average _____ Declining _____

Recent weight changes: Lost _____ Gained _____

Recent changes in sleep patterns: _____

Are you currently taking any psychotropic medications? Yes _____ No _____

If yes please list them _____

Prescribed by: _____

Are you willing to complete and sign a release of information so your psychiatrist or medical professional may be contacted to coordinate care? Yes _____ No _____

Have you ever used drugs for other than prescribed medical purposes? Yes _____ No _____

If yes please list them _____

Identify any history of psychiatric/emotional/drug or alcohol problems and treatment in your current family and in your family of origin: _____

Personality Information

Have you ever had any counseling or therapy before? Yes _____ No _____

Outcome _____

Briefly describe what brings you to therapy today. _____

Please circle any of the following words which best describe you **now**: active, ambitious, self-confident, persistent, nervous, hardworking, impatient, impulsive, moody, excitable, judgmental, intelligent, high strung, imaginative, calm, serious, easy-going, shy, good-natured, introvert, extrovert, likable, leader, follower, quiet, stubborn, submissive, lonely, self conscious, sad, fatigued, anxious, sensitive, optimistic, critical, sees the glass half empty, stressed, other _____

Other Information:

Are you currently dealing with any legal issues? Yes _____ No _____ If yes, please explain: _____

Religious/Faith Background

Current Faith involvement _____

Please explain any recent changes in your spiritual life _____

Consent - Please read and initial in the space provided.

_____ I understand that the information provided is true and accurate.

_____ I understand and agree that I am responsible for payment at the time services are rendered.

_____ I have also read and received a copy of Informed Consent and Information.

_____ I hereby consent for therapeutic services provided by Susan E. Justitz, Ph.D.

Patient's Signature/Date

Psychologist's Signature/Date

Credit Card Information For Billing (or missed appointments)

Credit Card Number

Expiration Date

CVV Code

Billing Zip Code

Billing address if different from above: _____

Signature authorizing payment for services rendered: _____