Christine M. Jean-Jacques, PhD
1400 Portland Ave., Suite 54
Rochester, NY 14621
Office: 585-417-6877
Fax: 585-363-5822
Website: www.drjean-jacques.com

Please sign below to acknowledge that you have read and understand the Appointment Policy, the Psychologist-Patient Services Agreement and the Privacy Notice. Your signature also acknowledges that you have been provided a copy of these notices to keep for your records.

______________________________ ______________________________
Printed Name Date

____
Signature

AUTHORIZED COMMUNICATION

I may need to contact you regarding scheduling or other matters. If contacting you and leaving a message would present a problem for you with regard to confidentiality, it is important that you let me know beforehand.

May I call you at home? ___Yes ___No __NA
May I leave a message at home? ___Yes ___No __NA
Home Phone Number: ________________________________

May I call your mobile phone? ____Yes ___No
May I leave a message on your mobile phone? ___Yes ___No
Mobile Phone Number: _________________________________

May I send you text message reminders of your appointments and copays? ___Yes ___No
May I send you email message reminders of your appointments and copays? ___Yes ___No
Email Address: ____

___________________________________ ________________________
Printed Name Date

____
Signature

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NEW PATIENT BILLING INFORMATION

Patient Name: ____
(Last) (First) (Middle Initial)

Address: ____
(Street Name & #) (City) (Zip Code)

Primary Phone: (______)________________ _____ Date of Birth: _____________________

Marital Status: ________________________ Sex: ___ Male ___ Female

Who is responsible for copays, deductibles, non-covered services and other balances?
(Please check only one) ___ Patient ___ Other

Patient's relationship to Guarantor/ Policy Holder: ___ Self ___ Spouse ___ Child ___ Other

Policy holder's name: ____

Name of Insurance: ____________________ Policy Number: ______________________

Phone number on back of card: ___________________ Policy holder's date of birth: _______

If your insurance requires authorization, have you requested this from your PCP? ___ Yes ___ No

In consideration of the provision of services to the above named patient rendered by Christine Jean-Jacques, PhD I agree to be obligated to pay any remaining balance due not covered by my/ patient's insurance carrier(s). In addition, I authorize Christine Jean-Jacques, PhD to release to parties responsible for payment of my/ patient's mental health service(s) bills such information as maybe necessary for the completion of financial obligation. All such transactions will be undertaken under conditions of strict confidentiality.

____
(Patient Signature) (Date)

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First Appointment Information

Last name:____________________ **First name:**__________________ **Middle initial**:________

Age:____ **Date of birth**:___________ **Birth Sex:** Male ___ Female ___ Unknown ____

Gender Identity:
___ Male
___ Female
___ Transgender Male/ Trans Man/ FTM
___ Transgender Female/ Trans Woman/ MTF
___ Genderqueer, neither exclusively male nor female
___ Additional category or other, please specify ______________________
___ Choose not to disclose

Race:
___ American Indian or Alaska Native
___ Asian
___ Black or African American
___ Hispanic or Latino
___ Native Hawaiian or Pacific Islander
___ White or Caucasian
___ Choose not to disclose

Marital status:__________ **Partner name & # years together** __________________________

Mailing Address:____

If you are currently employed: Occupation_____________Employer_______________
If applicable: Partner's Occupation___________________ Employer_______________

Please list 2 Emergency contacts: name, relationship to you and phone numbers:

____

____

If referred, by whom (name and relationship to you)_____________________________

Please describe your main reasons for seeking help at this time and what is motivating you to enter psychotherapy ____
____

What would you like to work on or see change as a result of psychotherapy?
____
____

What symptoms or issues are you experiencing? (circle all that apply):

Depression	anxiety/nervousness	health concerns
low motivation/apathy	fears/worries	headaches
fatigue/lack of energy	restlessness	sexual concerns
eating/appetite	panic attacks	backaches
sleep difficulties	obsessive thoughts	alcohol/drug use
low self-esteem/worthlessness	compulsive behavior	adjustment to illness
difficulty making decisions	disturbing/ unwanted thoughts	self-harm
distractibility		concerns about weight
suicidal thoughts/behaviors		

relationship problems	financial problems	impulsivity
social withdrawal	problems with work/school	rape/sexual assault
arguing/fighting		stress
loneliness		nightmares
anger/irritability		traumatic experience ______________________
communication problems		
adjustment concerns		
difficulty with assertiveness		
loss of loved one/grief		
lack of boundaries		
gender identity		
sexual identity		
safety concerns __________________________		

Have you experienced unwanted sexual attention/activity?	YES	NO	NOT SURE
Do you have history of sexual, physical or emotional abuse?	YES	NO	NOT SURE
Have you experienced domestic violence?	YES	NO	NOT SURE
Have you experienced a violent or otherwise traumatic event?	YES	NO	NOT SURE
Do you have a history of suicide attempts?	YES	NO	NOT SURE
Do you have a history of self harm (not intended to kill yourself)?	YES	NO	NOT SURE

Any other current Mental Health providers (name, contact information, what they are treating you for, how frequently you see them?)

____

____

Have you had any past mental health treatment providers? If so dates and reason for treatment:

____

____

Have you ever been hospitalized for a mental health or psychiatric issue? If so please list the year, hospital name and location and specific reasons for the hospitalization:

Do you have any medical or physical problems? If so please describe:

Medical specialists involved in your care (list name, contact information & specialty):

Current prescription medications:

Name	Dosage	Started Taking	Prescribed By	Purpose

Over the counter medications/vitamins/supplements:

Name	Dosage	Started taking	Purpose

Adverse reactions/Allergies to medications or other substances ______________________

Any other allergies____

How often do you use products with caffeine? (specify type, amount and frequency)

____

How often do you drink alcoholic beverages? (specify type, amount and frequency)

____

How often do you smoke cigarettes? _____________ If daily, how many per day?____

How often do you smoke Marijuana?_______________________________________

How often do you use any other illegal/illicit drugs? (specify type, amount and frequency)____

How often do you use prescription or OTC medication in a manner NOT prescribed by your own doctor? (specify type, amount and frequency)_______________________

Please share any past history of drug use ____________________________________

Have you ever wondered if you have a problem with alcohol or drugs? YES NO

Has anyone else ever suggested that you might have a drug or alcohol problem? YES NO

How often do you engage in "high risk" sexual behavior? (please explain)

____

Did you finish high school? YES NO ; If NO, how come?_______________________________

Did you attend post high school training or schooling? YES NO ; If so, specify what type completed. Please also list non completed programs and reason for not completing

____

Have you ever been in legal difficulty? If so, what circumstances and when?

____

____

____

____

____

____

Have you lost any person or any pet close to you? If so who, when and under what circumstances?

Who lives in your current household? (Name, age and relationship to you)

Other immediate family members not currently living with you (spouse, siblings, children or parents)

Family you grew up in: Parents (including step-parents) and siblings: Please include Name, Age (year if deceased), education and occupation

If a family member has ever been treated for emotional difficulties, mental health or psychiatric issues, please explain:

If anyone in your immediate or extended family has attempted or committed suicide, please explain____

If you have ever had concerns about the alcohol or drug use of someone close to you, please explain:

Anything else you want me to know?

Patient Name (Printed)

Patient Signature

Date