Lauren Pellizzi LLC

55 Route 35, Suite 5
Red Bank, NJ 07701
anxietytherapyredbank.com

Phone: (732) 705-1882
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A D U L T I N T A K E

Note: This information is confidential.

DEMOGRAPHIC INFORMATION			
Name:	DOB:	Age:	☐ M ☐ F ☐ Other
Home Address:			
Home Phone:	OK to leave a message? Y / N Preferred contact? Y / N		
Mobile Phone:	OK to leave a message? Y / N Preferred contact? Y / N		
Work Phone:	OK to leave a message? Y / N Preferred contact? Y / N		
Email address:	OK to leave a message? Y / N Preferred contact? Y / N		
Religion:	Sexual Orientation:		
How much does religion affect your daily life? (None) 0 1 2 3 4 5 (Very much)			
Referral Source:	May I thank them? ☐ YES ☐ NO		

EMERGENCY CONTACT INFORMATION	
Name:	Address:
Phone:	
Relationship to client:	

INSURANCE	
If you plan on submitting claims to your insurance company, please complete the information below.	
Name of policy holder:	Policy holder date of birth:
Name of Insurance Company:	
Policy #:	Group #:
Provider Services phone # for mental health/substance abuse services:	

EMPLOYMENT STATUS	
☐ I am self-employed ☐ I am unemployed ☐ I am retired ☐ I am a student ☐ I am on disability	
Occupation:	☐ Full time ☐ Part time
Employer/company:	Highest level of education:

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LEGAL HISTORY		
Are there any legal charges pending? ☐ YES ☐ NO		
Have you ever been arrested? ☐ YES ☐ NO For what charge?		
Have you ever been incarcerated (jail or prison)? ☐ YES ☐ NO		
Reason for incarceration:		
Have you ever had a DUI/DWI? ☐ YES ☐ NO HOW MANY:		
Are you currently on parole or probation? ☐ YES ☐ NO		

MEDICAL HISTORY	
Primary Care Physician:	Phone:
Psychiatrist:	Phone:
Current medical conditions (asthma, diabetes, etc.):	

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

Name the Drug	Strength	Frequency Taken

Allergies:

Name	Reaction You Had

PSYCHIATRIC HISTORY		
Psychiatric Hospitalizations and/or Residential Treatment		
Year	Reason	Hospital
Past outpatient treatment (i.e. therapist, psychiatrist, group therapy)		
Year	Reason	Treatment Provider

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FAMILY INFORMATION

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Length of current relationship:	Spouse/Partner's name:

Previous marriages, significant partners and length of relationships:

Children: (Include all **B**iological, **A**dopted, **F**oster, & **S**tep children)

Name	Gender	Age	Type (B, A, F, S)	Resides with you?

Siblings: (Include all **B**iological, **A**dopted, **F**oster, & **S**tep siblings)

Name	Gender	Age	Type (B, A, F, S)	Lived with you?

Parents: (check all that apply)

☐ Legally married ☐ Separated ☐ Divorced ☐ Mother remarried ☐ Father remarried
☐ Raised by someone other than parents ☐ Raised by single parent ☐ Mother is living ☐ Father is living

Is there a family history of mental health problems? ☐ YES ☐ NO

Has anyone in your family ever attempted or completed suicide? ☐ YES ☐ NO

Is there a family history of drug and/or alcohol abuse? ☐ YES ☐ NO

Previous or current involvement with DCP & P (formerly DYFS)? ☐ YES ☐ NO

Please indicate whether you have past experiences, or are currently experiencing any of the following…

Thoughts of suicide? ☐ **YES** ☐ **NO** Attempted suicide? ☐ **YES** ☐ **NO**

Engaged in self-harm behaviors (cutting, burning)? ☐ **YES** ☐ **NO**

Intentionally starved yourself or significantly restricted food intake? ☐ **YES** ☐ **NO**

Bingeing or purging (self-induced vomiting)? ☐ **YES** ☐ **NO**

Been a victim of or witnessed sexual abuse? ☐ **YES** ☐ **NO**

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Been a victim of or witnessed physical abuse or domestic violence? ☐ **YES** ☐ **NO**

Suffered a traumatic experience (car accident, natural disaster, other events which were traumatic to you)?
☐ **YES** ☐ **NO**

Chemical Use History

Please check which of the following substances you have used or currently are using:

	Amount	Frequency	Age of 1st Use	Age of last Use	Used in last 48 hours?	Used in last 30 days?
Alcohol						
Barbiturates						
Valium/Ativan/Xanax						
Cocaine/Crack						
Heroin/Opiates						
Marijuana						
PCP/LSD/Mescaline						
Inhalants						
Mushrooms						
Molly or Ecstasy						
Caffeine						
Nicotine						
Other…						

Have you ever felt you should cut down on your drinking and/or drug use? ☐ YES ☐ NO

Have people annoyed you by criticizing your drinking and/or drug use? ☐ YES ☐ NO

Have you ever felt bad or guilty about your drinking and/or drug use? ☐ YES ☐ NO

Have you ever used alcohol or drugs in the morning to steady your nerves or get rid of a hang-over? ☐ YES ☐ NO