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: 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: ______________________________________

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