Ariana Prawda, Psy.D.

Licensed Clinical Psychologist

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Personal Information

Name: _____ Date of Birth: _____

Address: _____

Cell Phone: _____ Email: _____

Gender/ Pronouns: _____ Ethnicity_____

Preferred Language: _____ Insurance Information:_____

If not the primary insured, name and date of birth of the primary insured: _____

Relationship Status: _____

Highest Level of Education Achieved:_____

Occupation: _____

Who referred you:_____

Emergency Contact

Name: _____ Phone: _____

Relationship to client: _____

Billing Information (maintained on file for unpaid invoices)

Credit card: Visa___ Master Card___ Other_____ Credit card number: _____

Expiration Date:_____ Security code (CVV):_____

Billing address (if different from above): _____

Name (if different from above): _____

Current Situation

Why are you seeking therapy at this time? _____

_____

_____

Have you recently experienced any stressful event(s)? If so, please describe:

_____

_____

Are you currently in therapy? _____ If yes, please specify what kind: _____

Name of therapist(s): _____

Do you currently see a psychiatrist? _____ If yes,

Psychiatrist's name: _____ Phone: _____

Do you currently take psychiatric medication(s)? _____
If yes, who prescribed the medication? _____
Please list all current medications: _____
Please list any current medical problems or chronic health problems:_____

Treatment History

Have you ever been given a psychiatric diagnosis/es? _____
Please list any/all past diagnoses: _____
_____
Have you had therapy in the past? _____
Time attended: _____ Type of therapy: _____
Time attended: _____ Type of therapy: _____
Time attended: _____ Type of therapy: _____
Have you ever been hospitalized for psychiatric illness? _____
Year: _____ Reason for hospitalization: _____
Year: _____ Reason for hospitalization: _____
Have you taken psychiatric medication(s) in the past? _____
Please list any past medications: _____
Have you ever made a suicide attempt/gesture?_____
Have you had problems with alcohol or substance abuse?_____

Please list any providers (physician, therapist, healer) with whom it is important that I collaborate. I will request a release of information for each of these providers.
Name of provider: _____ Phone: _____
Address: _____
Type of care provided: _____

Name of provider: _____ Phone: _____
Address: _____
Type of care provided: _____

List your goals for counseling in order of importance to you:
1._____
2._____
3._____
Please add any other information which you believe is important for me to know:
_____
_____
_____