The Cognitive Therapy Institute, A.P.C.
A Psychological Corporation

3262 Holiday Ct, Ste 220 • La Jolla, CA 92037 • Tel. (858) 450-1101 • Fax (858) 450-1161

Albert Modad, Psy.D.
Licensed Psychologist #PSY29697

Please provide the following information to help us in planning services for you. All information in this form is confidential and will not be released without your prior written consent.

Name: ______ **Home Tel#** ______ **Cell/Work Tel #** ______

Date of Birth: ______ **Age:** ______ **Marital Status:** ______ **Email:** ______

SSN: ______ **Education:** ______

Home Address (include City, State, Zip)**:** ______

Name of Parent/ Guardian (if minor): ______ Mother: ______ Father: ______

Occupation: ______ **Current Position:** ______ **For how long?** ______

Employer: ______ **Work Address:** ______

Name of Physician & Address: ______ **Physician Tel #** ______

Did you call Griebel billing service to provide all relevant insurance information? Yes No I will (circle one)

I ___________________________ hereby authorize The Cognitive Therapy Institute, A.P.C. and Albert Modad, PhD. to release any necessary information to my insurance company ______________________ to process this claim. This information may include the diagnosis, dates of service and any other information to assist in processing your claim. I agree to inform The Cognitive Therapy Institute if there is any change in insurance carrier or other relevant information.

____________________________________ ___________________

Signature Date

Please list any other people currently living in your home:

Name: ______ Age: ______ Relationship: ______

Name: ______ Age: ______ Relationship: ______

Name: ______ Age: ______ Relationship: ______

Name: ______ Age: ______ Relationship: ______

Please list any of your children who are not living in your home, including any adult children:

Name: ______ Age: ______ Relationship: ______

Name: ______ Age: ______ Relationship: ______

Name: ______ Age: ______ Relationship: ______

Name: ______ Age: ______ Relationship: ______

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Person to notify in case of emergency (required information)

Name: ______________________ Relationship: ______________________ Tel (day/eve) ______________________

Address: ____

Please describe your reasons for seeking help at this time: ______________________

____

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____

How long have you been having these difficulties? ______________________

Nervousness	Depression	Fears
Shyness	Sexual Problems	Suicidal Thoughts
Divorce	Boredom	Finances
Drug Use	Alcohol Use	Friends
Anger	Self Control	Unhappiness
Sleep	Stress	Work
Relaxation	Headaches	Dating Skills
Legal Matters	Chronic Pain	Making Decisions
Loneliness	Self –esteem	Concentration
Education	Career Choices	Performance Anxiety
Health Problems	Nightmares	Marital/Relationship
Parenting	Eating Disorders	Irritability
Mood Changes	Confusion	Thinking Problems
Family Conflict	Social Anxiety	Weight Loss
Racing Thoughts	Attention	Organization

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Please describe any major changes in the past two years:

If you have previously received treatment from a mental health professional (Psychiatrist, Psychologist, or Counselor) please provide the following information: when this treatment occurred, reasons for seeking treatment, and the outcome. Also, please describe anything that you found was helpful (positive) and anything that was not helpful (negative) about this treatment:

Psychiatric Hospitalizations? ____ **No** ____**Yes** **When/ Where?**____

Please list any prescription or non-prescription medications you are currently taking:

Medicine	Dosage	Date Started	Purpose

Name & Telephone # of Personal Physician (family, internist):

Name & Telephone of Psychiatrist (if applicable)

Please list any health problems you are currently experiencing:

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Please describe your alcohol, tobacco and/or drug use (include amount used and how often):

Please describe any positive health behaviors you regularly do (i.e., exercise, meditation, yoga, etc.):

Please add any other information that you feel would be helpful:

How did you learn about The Cognitive Therapy Institute?

Who referred you to the Institute?

May we write them a letter thanking them for the referral? (initial here if yes):

Signature **Date**

Parent/Guardian Signature **Date**