

Client Information

Client's Name: _____ Today's Date: _____

Street: _____ Apartment #: _____

Town: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Permission to call Permission to leave message Restrictions: _____

Marital Status: Single Married Separated Divorced Widowed

DOB: _____ To which gender do you most identify? _____

Employer: _____

Occupation: _____

10 digit emergency number for your area: _____

Responsible Party

Please complete the following information regarding the person who is financially responsible for this account if different than above:

Name of Responsible Party: _____

Relationship to Client: _____

Date of Birth: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____

Occupation: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Insurance Information

Primary Insurance Company: _____ Telephone: _____

ID #: _____ Group #: _____ Effective Date: _____

Subscriber's Name: _____ Relationship to client: _____

Subscriber's Address: _____

Subscriber's DOB: _____ Subscriber's SS #: _____

Employer: _____ Occupation: _____

Address for submitting claim: _____

Authorization #: _____ Co-Payment: _____ Deductible: _____ # Visits/year _____

Insurance is a complex issue. Please call your insurance company to verify what your benefits are and to confirm that I am in your network. Ultimately you are responsible for payment of fees that your insurance company does not agree to cover and for discussing with your insurance provider any disputes regarding coverage; therefore, it is important to fully understand your mental health coverage.

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of any medical information necessary to process insurance claims associated with my treatment with Dorothy Gasparro EdS, LPC, LCMHC, LMHC, NCC, CTP. I permit a copy of this authorization in place of the original.

Signature: _____ Date: _____

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to Dorothy Gasparro EdS, LPC, LCMHC, LMHC, NCC, CTP for services rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. Either I or my insurance company at any time in writing may revoke this authorization.

Signature: _____ Date: _____

Emergency Contact: _____ **Phone #:** _____

Relationship: _____ **Cell/Work #:** _____

I authorize Dorothy Gasparro EdS, LPC, LCMHC, LMHC, NCC, psychotherapist to obtain and release necessary information to my emergency contact for the purpose of managing and responding to emergency situations. I understand that the information to be released may be confidential and protected from disclosure. The information that is disclosed as a result of this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of confidential protected health information. I understand that I have the right to cancel this authorization at any time by submitting a written request.

Client Signature _____ **Date** _____

Presenting Issue and Goals

What is happening in your life which resulted in this appointment?

What are your goals of therapy?

Chief Complaints (please check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Anger/Frustration | <input type="checkbox"/> Isolation/Social withdrawal |
| <input type="checkbox"/> Anxiety/Panic | <input type="checkbox"/> Low Energy |
| <input type="checkbox"/> Appetite change (more/less) | <input type="checkbox"/> Low Self-esteem |
| <input type="checkbox"/> Argues | <input type="checkbox"/> Obsessions or compulsive behavior |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Blames others | <input type="checkbox"/> Physical abuse issues |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Poor concentration |
| <input type="checkbox"/> Chills/Hot flashes | <input type="checkbox"/> Problems with social relationships |
| <input type="checkbox"/> Confusion/Not thinking clearly | <input type="checkbox"/> Racing thoughts |
| <input type="checkbox"/> Delusions/Hallucinations | <input type="checkbox"/> Religious/Spiritual Concerns |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Sadness/Loss |
| <input type="checkbox"/> Easily agitated or annoyed | <input type="checkbox"/> Sexual abuse issues |
| <input type="checkbox"/> Excessive behavior, e.g., gambling, spending | <input type="checkbox"/> Sexual Concerns |
| <input type="checkbox"/> Excessive use of alcohol | <input type="checkbox"/> Sleep Disturbances (more/less) |
| <input type="checkbox"/> Excessive use of drugs | <input type="checkbox"/> Spousal Abuse Issues |
| <input type="checkbox"/> Excessive energy | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Excessive guilt | <input type="checkbox"/> Thoughts of hurting myself |
| <input type="checkbox"/> Excessive use of prescription medications | <input type="checkbox"/> Tingling/numbness |
| <input type="checkbox"/> Feeling that you're not real | <input type="checkbox"/> Trembling/Shaking |
| <input type="checkbox"/> Feeling that things around you are not real | <input type="checkbox"/> Unpleasant thoughts won't go away |
| <input type="checkbox"/> Hopelessness or Worthlessness | <input type="checkbox"/> Other problems or symptoms important to note |
| <input type="checkbox"/> Impulsivity | |
| <input type="checkbox"/> Increased Libido | |
| <input type="checkbox"/> Increase in Risky Behavior | |

Recent Life Changes

- | | |
|--|--|
| <input type="checkbox"/> Move/Relocation | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Change of School/employment | <input type="checkbox"/> Unemployment/Financial issues |
| <input type="checkbox"/> Separation or Divorce | <input type="checkbox"/> Victim of Crime |
| <input type="checkbox"/> Birth of Child | <input type="checkbox"/> Death |
| <input type="checkbox"/> Catastrophic Illness | <input type="checkbox"/> Legal Issues |
| <input type="checkbox"/> Other stressful events you've experienced recently: | |

Family Constellation

Please list people living in household.

Name	Relationship to Client	Age

Current Functioning

Please rate how your problem(s) or emotional status is currently affecting functioning in the following areas:

	None	Mild	Moderate	Severe
Family relations	_____	_____	_____	_____
Work/School performance	_____	_____	_____	_____
Social relations	_____	_____	_____	_____

Have you ever...

- | | | | |
|--|------------------------------|------------------------------|-------|
| Attempted Suicide | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ |
| Engaged in self-injurious behavior | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ |
| Been a victim or witnessed sexual abuse | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ |
| Been a victim or witnessed domestic violence | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ |
| Suffered a traumatic experience | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ |
| Do you currently have suicidal thoughts | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |

Do you drink alcohol more than once a week? Yes No

How often do you engage in recreational drug use?
 Daily Weekly Monthly Infrequently Never

Are you currently in a romantic relationship? Yes No

- If yes for how long? _____
- On a scale of 1 to 10 how would rate your relationship? _____

Religious Affiliation? _____

Active? Yes No

Medical History

Family Doctor (PCP) _____ Phone Number _____

Please list any medical conditions or health problems.

What medications are you currently taking, including over-the-counter medications?

Have you ever been in the hospital overnight? Yes ___ No ___
If yes, list when and why:

Have you ever received any of the following psychiatric services?

- | | |
|--|--|
| <input type="checkbox"/> Outpatient counseling | <input type="checkbox"/> Drug/Alcohol Rehab |
| <input type="checkbox"/> Inpatient Psychiatric Hospital Stay | <input type="checkbox"/> Child Study Team Evaluation |
| <input type="checkbox"/> Psychiatric Screening Services | |

With Whom? _____ When: _____

What was accomplished?

Have you ever been given a psychiatric diagnosis: Yes No
If so, please indicate the diagnosis:

Do you now or have you ever had any of the following? (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Unusual Habits | <input type="checkbox"/> Chronic headache |
| <input type="checkbox"/> Memory problems | <input type="checkbox"/> Significant physical trauma or injury |
| <input type="checkbox"/> Seizures or convulsions | <input type="checkbox"/> Tiredness/weakness |
| <input type="checkbox"/> Problems with rage, violence | <input type="checkbox"/> Any operations or surgery |
| <input type="checkbox"/> Heart condition | <input type="checkbox"/> Inherited disease |
| <input type="checkbox"/> Attention problems | <input type="checkbox"/> Tics |
| <input type="checkbox"/> Lead Poisoning | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Substance use | <input type="checkbox"/> Eating problems |

Family Information

Please check those illnesses, which have been present in family members. (Please list the relationship of the family member to you.)

- | | | |
|--|--|---|
| <input type="radio"/> Seizures | <input type="radio"/> Schizophrenia | <input type="radio"/> Obsessive-compulsive disorder |
| <input type="radio"/> Neurological problem | <input type="radio"/> Eating problems, e.g. anorexia/bulimia | <input type="radio"/> History of mental health issues |
| <input type="radio"/> Substance Abuse | <input type="radio"/> Depression | |

Has anyone in your family attempted or died by suicide? Yes NO

What additional information do you believe is important to share at this time?

