PATIENT INFORMATION:

Date:_____

Last Name:_____First_____Middle_____

Address_____

City/State/Zip_____Soc. Sec. #_____

Marital Status: S M D W Sex: M F Date of Birth ___/___/___ Age_____

Home Phone_____Cell Phone_____

Employer_____Work Phone_____

Employer Address_____

SPOUSE/GUARDIAN

Spouse/Guardian_____Date of Birth___/___/___

Employer Name_____Soc. Sec. #_____

Address (if different)_____

Home Phone_____Work Phone_____Cell Phone_____

EMERGENCY CONTACT

Name_____Relationship_____

Address_____Phone_____

INSURED OR RESPONSIBLE PARTY

Name_____Relationship_____

Address_____

Soc. Sec. #_____Date of Birth___/___/___

Employer_____Work Phone_____

INSURANCE INFORMATION

Name of Insurance Company_____

Policy Number_____

Group Number_____Effective Date_____

Policyholder's Name_____Relationship_____

Policyholder's Date of Birth___/___/___ Policyholder's Soc. Sec. #_____

I hereby assign medical benefits to which I am entitled to this office, unless revoked by me in writing. I authorize any information needed to be released to my insurance company for the purpose of authorizing and processing my claims. I understand that I am fully responsible for, and will assume all my charges not paid by my insurance. I UNDERSTAND THAT I WILL BE CHARGED IN FULL FOR ANY APPOINTMENTS NOT KEPT UNLESS 24 HOURS NOTICE IS GIVEN TO THE OFFICE.

_____ _____

Signature Date

Date_____

Last Name_____First_____Middle_____

Soc Sec #_____DOB___/___/___ Age_____

Address_____

City_____State_____ZIP_____

Home Phone_____Work_____Cell _____

How did you learn of our practice?_____

What would you like to see change as a result of counseling?

_____ _

_____ _

_____ _

_____ _

Family: (List 4 adjectives to describe each relative and their personalities, i.e. good, kind, stern, domineering)

Father's Age_____(Living, Deceased) Occupation_____

Four adjectives to describe your father:

1._____2._____3._____4._____

Mother's Age_____(Living, Deceased) Occupation_____

Four adjectives to describe your mother:

1._____2._____3._____4._____

Siblings: Please list all brothers and sisters. Indicate whether if the sibling is half, step, or adopted. Please describe using 3 adjectives.

Name	Age	Description
1._____		
2._____		
3._____		

Please identify blood relatives (including Aunts, Uncles, and cousins) who experienced problems with depression, anxiety, phobias, anger, drugs, or alcohol, or have been treated by a professional in the mental health field OR do you believe needs treatment? Please list below:

_____ _

_____ _

_____ _

_____ _

Other relatives who have interesting histories

_____ _

_____ _

_____ _

_____ _

Present marital status: Single Married Divorced Widowed

How many times have you been married:_____ Number of children:_____

Please list your children and indicate whether child is a stepchild or adopted:

Name	Age	Where do they live?
1._____		
2._____		
3._____		
4._____		

If you have been terminated or fired from work please explain:

_____ _

_____ _

_____ _

_____ _

What is your current occupation?_____

What do you enjoy and or not like about your present employment?

_____ _

_____ _

_____ _

What is your spouse's occupation and level of satisfaction?

_____ _

_____ _

_____ _

When and where was your last vacation?

_____ _

_____ _

_____ _

Please describe any concerns or worries that you may have about loved ones, such as your parents or children:

_____ _

_____ _

Please identify hobbies or special interests:

1._____

2._____

3._____

Please answer all symptoms that currently bother you or have bothered you in the last 6 months with a Y for yes or an N for no.

_____Sleep Disturbance

_____If yes, difficulty going to sleep?

_____Awakening throughout the night or early morning

_____Are you blue, sad, despondent?

_____Do you lack energy?

_____Are you interested in your usual pastimes?

_____Have you lost weight? _____#lbs

_____Have you gained weight? _____#lbs

_____Have you lost interest in sex?

_____Have you thought you are more energetic than usual?

_____Have you experienced a decrease in concentration?

_____Do your thoughts run quickly from topic to topic?

_____Do you have thoughts of fear of others?

_____Have you made unwise purchases lately?

_____Do you have trouble speaking in public to groups?

_____Have you experienced a panic attack?

_____Do you have a racing pulse?

_____Do you have episodes of shortness of breath?

_____Have you ever thought you would go crazy or lose control?

_____Are you ever compelled to do something that seems silly, i.e. count things?

_____Do you experience a thought that you cannot seem to get out of your mind?

_____Do you find yourself consuming huge amounts of sweets or starches?

_____Do you double check doors, appliances, or locks when leaving home?

_____Do you have difficulty making decisions?

_____Do you cry for no reason?

_____Do you worry about what others think?

_____Do you feel responsible if something/anything goes wrong?

_____Have you been so mad or irritable that you have broken something?

_____Do family members say that you are irritable?

_____Have you done things on a whim or impulse?

_____Have you experienced thoughts of self-harm?

_____Do you worry about hurting others' feelings?

_____Have you felt suddenly scared for no reason?

_____Have you been feeling worthless?

_____Have you been feeling like everything is an effort?

_____Do you feel that you are able to maintain control of your life?

Describe additional symptoms that bother you:

_____ _

_____ _

Describe concerns you may be feeling about any relationships:

_____ _

_____ _

Please describe any medical problems:

_____ _

_____ _

What significant losses have you experienced:

_____ _

_____ _

_____ _

Please describe traumas that have affected your life:

_____ _

_____ _

Please list medications you are currently taking:

_____ _

_____ _

Please list allergies:

_____ _

Do you have a problem with your temper? Yes No Not Sure

If yes, please describe issues with your anger:

_____ _

_____ _

How much alcohol do you drink in a typical week?

_____ _

In the past, have you ever felt you ought to cut down on the amount of alcohol or drug use?

_____ _

In the past 30 days, have you ever felt guilty or bad about your drinking or drug use?

_____ _

In the past 30 days, have people annoyed you by criticizing your drinking or drug use?

_____ _

In the past 30 days, have you felt you need a drink or use drugs to steady your nerves or to get rid of a hangover?

_____ _

Please check any area of your life affected by alcohol or drugs: _____No life areas

_____Legal _____Physical _____Family _____Social _____Financial _____Leisure

_____Emotional _____Work _____School _____ Spiritual Please describe any checked

_____ _

_____ _

Are other family members affected by alcohol or drug use, including abuse of prescription medication?

_____No _____Father _____ Mother_____ Brother_____ Sister_____ Children
_____Grandparents_____ Other significant people in your life

Please describe any concerns or observations:

_____ _

_____ _

Have you ever had heart problems? If yes, please give details:

_____ _

_____ _

Have you ever had problems with your thyroid gland?

_____ _

Did you have any serious childhood diseases? If yes, please describe:

_____ _

_____ _

Please describe any previous hospitalizations:

_____ _

Are you currently under a doctor's care?

_____ _

If we may contact your doctor, please provide name and phone number (if possible):

_____ _

If you exercise, please describe:

_____ _

In the past 12 months, what type of drugs have you taken?

_____ _

_____ _

How much do you smoke?

_____ _

How do you relax?

_____ _

_____ _

_____ _

By signing below, I am acknowledging that I have read and understood the HIPAA statement and the treatment process of Dr. Gina Hartmeier. We look forward to helping you.

_____ _____

Signature Date