Patient Information and History

(Please Print)
Date_____
Name_____DOB_____
Address_____

Phone_____ Can I call and/or leave a message or text: Yes / No
Emergency Contact and Phone number_____

Identifying Information:

Age:_____ Gender identity:_____ Relationship Status:_____

Hobbies/Interest_____

_____

Presenting Problem/Precipitating Events/Hx of Problem:

Reason for seeking treatment?_____

_____

_____

How long has this been distressing?_____

_____

Previous Psychiatric History:

Any previous counseling?_____

Reason for termination_____

Are you seeing a psychiatrist?_____Name:_____

Have you previously seen a psychiatrist?_____Name:_____

If yes, when, where, and was/is it helpful?_____

_____

Have you received inpatient psychiatric care?_____Voluntary/Involuntary_____

Have you attended a PHP or IOP program? _____Successfully completed? _____

Medical History:

Primary Care Physician:_____ Medical Practice_____

Phone:_____ Date of last physical exam:_____

Previous Medical History:_____

_____

_____

Major Medical Conditions:_____

_____

_____

Current Medications and reason for taking: (attach list or continue on back if necessary)

_____

_____

_____

Substance Abuse History:

Category	Age of First use	Frequency of use in last month	Date/amount of last use
Alcohol			
Marijuana			
CNS stimulant Cocaine, Ritalin, Meth			
Barbituates/ Benzodiazepines Valium, Xanex			
Opiates/painkillers heroin, morphine, methadone, oxycodone			
Hallucinogens LSD PCP ecstasy			
Inhalants			
Tobacco/Nicotine Vaping			

Are you/were you ever involved in any treatment programs (AA, NA.OA., etc)?_____ Which program?_____ If not attending, Why?_____

_____

Personal History/Family of Origin History:

Raised by:

Family described as: Stable Supportive Chaotic Abusive Other

Siblings (gender & age):

Family of origin abuse issues: YES NO Specify:

Family of origin mental health issues: YES NO Who and diagnosis:

Present sexual orientation: Heterosexual Homosexual Bisexual Transgender Asexual Pansexual

Currently living with: How long:

# of Marriages (_____) # of Divorces (_____) # of Committed Relationships (_____)

Children/Name/Age/Gender:

Additional Information (Lifestyle, Support System, Stressors, Spirituality, Cultural, Etc.):

Legal History:

Arrests? Lawsuits?

Legal issues:

Comments:

Is there anything that you feel would be helpful for me to know about you?

Treatment Goals: What would you like to achieve in therapy_____

_____

_____

_____

Check all that apply to you:

[__] Depression
[__] Low energy
[__] Low self-esteem
[__] Poor concentration
[__] Hopelessness
[__] Worthlessness
[__] Guilt
[__] Sleep disturbance (more / less)
[__] Appetite disturbance (more / less)
[__] Thoughts of hurting yourself
[__] Thoughts of hurting someone
[__] Isolation / social withdrawal
[__] Sadness / loss
[__] Stress
[__] Anxiety / panic
[__] Heart pounding / racing
[__] Chest pain
[__] Trembling / shaking
[__] Sweating
[__] Chills / hot-flashes
[__] Tingling / numbness
[__] Fear of dying
[__] Fear of going crazy

[__] Nausea
[__] Phobias
[__] Obsessive/compulsive behaviors
[__] Thoughts racing
[__] Excessive energy
[__] Can't hold on to an idea
[__] Excessive behaviors (spending, sex, talking, gambling)
[__] Not thinking clearly / confusion
[__] Feeling that you are not real
[__] Feeling that things around you are not real
[__] Lose track of time
[__] Unpleasant thoughts won't go away
[__] Anger / frustration
[__] Easily agitated / annoyed
[__] Defies rules
[__] Blames others
[__] Argues
[__] Excessive use of drugs or alcohol
[__] Excessive use of prescription medications
[__] Blackouts
[__] Physical abuse issues
[__] Sexual abuse issues
[__] Spousal abuse issues

Jill A. Yoerger-Churchwell, L.C.S.W.

Client Name: _____ Date of Birth: ____/____/____

[___] I will be paying privately for services rendered at $_____ per session.

[___] I am requesting that my insurance be billed for services rendered.

[__] I understand that I am responsible for the co-pay indicated by my insurance.

Insurance Information:

Insurance_____

Primary policy holder_____

Policy number_____

I understand that I will be charged a $75 fee for missed sessions or appointments cancelled less than 24 hours prior to appointment.

Assignment and Release:

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Jill A. Yoerger-Churchwell, LCSW all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Jill A. Yoerger-Churchwell, LCSW to release all information necessary to secure payment of benefits.

_____

Signature of Responsible Party **Date**

Jill A. Yoerger-Churchwell, LCSW
Authorization for Release of Confidential Information

Client Name:

I authorize Jill A. Yoerger-Churchwell, LCSW and the persons or entities listed below, or their representatives, to mutually release and disclose my health information.

I understand that by signing this General Authorization I am authorizing Jill A. Yoerger-Churchwell, LCSW to disclose my health information to the persons and entities listed below and that any health information or other confidential information in the possession of the persons and entities listed below may be disclosed to above mentioned My health information includes, without limitation, any records, reports, test results, opinions, assessments and any other information relating to medical, emotional, educational or psychological condition. Disclosure may also be made to describe my condition, progress and treatment. I further understand that my health information may be disclosed to any person or entity providing any payment for services I receive, including insurance companies.

I understand that I may revoke this authorization at any time by sending a written notice of revocation to the therapist listed on this form. I understand that my revocation of this *General Authorization* will not affect a disclosure that Jill A. Yoerger-Churchwell, LCSW has already made under this authorization.

I understand that information used or disclosed under this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by the confidentiality rules.

I waive any right of privacy that I may have in connection with the disclosures hereby authorized. This authorization is only valid until _____ [fill in date], or until three months after my file is closed by the therapist.

Name	Phone or Email	Client Initials
Name	Phone or Email	Client Initials
Name	Phone or Email	Client Initials
Name	Phone or Email	Client Initials
Name	Phone or Email	Client Initials

Client Signature	Date
Guardian (if appropriate)	Date
Therapist	Date