Discover Healthy Ways to Navigate Stressful Times....

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PATIENT INFORMATION FORM

Name: _____
First Last MI

Street Address:_____

City:_____State:_____Zip:_____

Phone: (H) (____)_____Cell: (____)_____Work: (____)_____

E-mail address_____

DOB____/_____/_____ M / F Driver's License #_____

SS# _____

Employer_____ Title: _____

Primary Care Physician_____Phone: (____)_____

Permission to contact Primary Care Physician to coordinate care? ____Yes _____No

Person to contact in emergency:_____Phone: (____)_____

Referred by:_____Phone: (____)_____

RELEVANT MEDICAL HISTORY: (History, current conditions, any change in medical condition)

MEDICATIONS:

PAST AND PRESENT MEDICAL CARE:
(Specify major problems, accidents, hospitalizations)

PAST AND PRESENT COUNSELING/PSYCHOTHERAPY, HOSPITALIZATIONS:
(include any prior history of treatment for alcohol or drug addiction)

1. Psychotherapist_____ Dates_____

Initial reason for seeking treatment:

Outcome:

2. Psychotherapist_____ Dates_____

Initial reason for seeking treatment:

Outcome:

REASON FOR SEEKING PSYCHOTHERAPY TODAY:

PAST AND PRESENT DRUG/ALCOHOL USE/ABUSE OR OTHER ADDICTIONS:

FAMILY HISTORY OF ALCOHOLISM, VIOLENCE, SUICIDE OR CRIMINALITY:

HISTORY OF SEXUAL, PHYSICAL ABUSE OR OTHER TRAUMA:

PRESENT LIVING SITUATION:

SOCIAL SUPPORTS:

STRESSORS:

INFORMED CONSENT:

I consent to assessment and treatment under the care of_____.

By my signature below, I assume responsibility for all fees incurred. Charges are due and payable at the time of service unless other arrangements have been made to bill the following insurance providers for partial payment of their contracted fee:

_____ Aetna _____ Anthem Blue Cross ____ MHN _____ TriWest Choice Program

_____ Cigna

If one of the above insurance providers is to be billed I understand that if my insurance provider fails to provide reimbursement that I am responsible for payment of the full fee for treatment. I further understand that I am responsible for my portion or copay of the insurance contracted rate with this provider for payment at the time of service.

I am happy to receive quarterly e-newsletters from Dr. Linda Collins announcing workshops and educational information to support your therapy experience. ___Yes ___No

_____

Signature Date