87 Maple Avenue; Red Bank, NJ 07701
3930 Richmond Avenue – Suite 104; Staten Island, NY 10312
P:347.815.0699

## Patient Information

Name: ________________________________________________ Date: ___________________

Address: ___________________________________________________________________________

City/State/Zip: _____________________________________________________________________

Home Phone: _____________________ Work/Cell Phone: ___________________________________

Where is the best place to leave a message? __________________________________________

Date of Birth: ___________________ Age: ___________

Relationship Status (please check one):

Single _______ Cohabiting ______ Married _____ Separated _____ Divorced _____

Widowed _____

Emergency Contact: __________________________________ Phone: ___________________________

Relationship to You:

_____________________________________________________________________________________

Email Address: ______________________________________________________________________

## Patient Insurance

Name of Insurance: __________________________________________________________________

Insurance ID: _______________________________________________________________________

Group Number: _______________________________________________________________________

Address: ____________________________________________________________________________

Phone Number: _______________________________________________________________________

Insured Name: ___________________________________________________________

Insured Date of Birth: _______________________________________________________

Person Responsible for Payment of Not Insurance: ___________________________________

## EDUCATION AND EMPLOYMENT AND LEISURE

Education: _____________________________________________________________________

Occupation: ____________________________________________________________________

Employer: ______________________________________________________________________

May I contact you at work? ____ Yes ____ No

Address: _______________________________________________________________________

City/State/Zip: __________________________________________________________________

Home Phone: _________________________________ Work Phone: ____________________

If Patient is a minor, Legal Guardian's Name: ____________________________________

Guardian's Address and Phone Number: ___________________________________________

________________________________________________________________________________

What are some things you like to do for fun (sports, hobbies, leisure)? ______________________

________________________________________________________________________________

## FAMILY AND RELATIONSHIP INFORMATION

List members of your family and all others in your home:

| Name | Age | Relationship | Occupation |
| --- | --- | --- | --- |
| ____________________ | _______________ | ________________ | ____________________ |
| ____________________ | _______________ | ________________ | ____________________ |
| ____________________ | _______________ | ________________ | ____________________ |
| ____________________ | _______________ | ________________ | ____________________ |
| ____________________ | _______________ | ________________ | ____________________ |

Are your biological parents: Married _______ Co-habiting ________ Separated ___________

Divorced _________ Never Married ________

If your parents are SEPARATED or DIVORCED, please indicated:

How old were you at the time of the separation/divorce? ________________________________

If you were a minor, which parent did you primarily reside with? _________________________

Did you maintain contact with your non-custodial parent (please describe) : _________________

______________________________________________________________________________

What was your role in your family of origin (caretaker, mediator, black sheep, rebel)? _______________

______________________________________________________________________________________

Are you satisfied with the quality, frequency, and / quantity of your dating and romantic relationships?

Yes _________ No __________

If no, please describe: ____________________________________________________________

If you are currently in a relationship, how satisfied are you with your relationship: __________________

What do you enjoy most about your boyfriend/girlfriend/partner/spouse? ___________________________

______________________________________________________________________________________

What do you most disagree on most frequently/intensely? _____________________________________

______________________________________________________________________________________

Have you ever been the victim of domestic violence? Yes ______________ No __________________

If yes, please describe and indicate if this abuse is still ongoing: __________________________

______________________________________________________________________________

Has anyone in your family had a psychiatric history? Yes _______________ No __________________

If so, please indicate relationship to you, living/deceased, Age, Occupation (past and present) and Mental Health Issues/Psychiatric Diagnosis/Alcohol/Substance Abuse): ____________________

______________________________________________________________________________

______________________________________________________________________________

## PHYSICAL HEALTH

Name of Physician: ____________________________ Phone: _________________________________

Date of Last Physical Exam: ____________________________________________________________

Medications for Medical Issues: ___________________________________________________________

_____________________________________________________________________________________

Significant Medical History (chronic conditions, accidents, major illnesses or surgeries):

_____________________________________________________________________________________

_____________________________________________________________________________________

## PSYCHOLOGICAL TREATMENT

Are you currently in treatment with another therapist? _________________________________________

If yes, please list your therapist's name: ____________________________________________

Type/Length of Prior Treatment:-

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Provider's Name and Address:

____________________________________________________________

_____________________________________________________________________________________

Have you ever been hospitalized for psychiatric reasons? If so, list dates and locations:

_____________________________________________________________________________________

_____________________________________________________________________________________

Are you currently taking medication for a psychiatric problem? Yes _______ No ________

If yes, please list the name, dosage, and dates of each of your medications:

RX Name/Dosage/Start Date:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Prescribing Provider:

Name: _______________________________________________________________________________

Address (City/State/Zip):

______________________________________________________________________________

Phone #: ______________________________________________________________________

Have you ever taken medication for psychiatric issues if not currently: ___________________________

______________________________________________________________________________

Have you ever experienced a trauma? Yes ________ No ___________

If yes, please describe: ____________________________________________________________

______________________________________________________________________________

Have there been any sources of stress you have experienced in the past year? Yes ______ No ______

If yes, please describe: ____________________________________________________________

______________________________________________________________________________

Do you exercise? Yes _________ No __________

If yes, do you feel your exercise is excessive? _________________________________________

Have you ever had an eating disorder (Anorexia, Bulimia, or Binge Eating)? Yes _______ No ________

If yes, please describe/when: _______________________________________________________

Have you ever had or do you currently have a problem with substance abuse? Yes _______ No _______

If yes, please indicate if alcohol, medication, illicit drugs as well as when and duration: _______

______________________________________________________________________________

How much coffee, tea, or caffeine do you consume daily? _____________________________________

Are there situations or people that you avoid because they make you feel anxious? Yes _____ No _____

If yes, please describe: ___________________________________________________________

_____________________________________________________________________________

Have you ever had a period of two days or more when you experienced any of the following (check all that apply):

Decreased need for sleep: ________ Very Talkative: ________ Racing Thoughts __________

Unusually high self esteem: _____________ Unusually desire to spend money: ______________

Easily Distracted: ____________ Driving Very Fast: ___________ Very Irritable/Angry: ____________

Please check the issues you are currently seeking help for: (check each one):

Anxiety _______ Suicidality _______ Anger _______ Depression _______

Assertiveness _______ Loneliness _______ Hopelessness _______ Low Energy _______

Aggression/Violence _______ Problem Solving _______ Mood Swings _______

Regrets _______

Relationship/Marital Issues _______ Body Image _______ Irritability _______ Fears _________

Physical Complaints _______ Job/Career Issues _______ Shyness _______ Insomnia __________

Social Skills _______ Self-Criticism _______ Panic _______ Alcohol/Substance Abuse __________

Obsessive thoughts _______ Procrastination _______ Self-Esteem _______ Sexual Issues ________

Is there anything else you would like me to know about you? ___________________________________

__________________________________________________________________________________

## CURRENT CONCERNS

Briefly describe your reasons for seeking help at this time: _____________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

Referred by? ___________________________________________________________

Signature ______________________________________________ Date _________________________