PATIENT PERSONAL HEALTH INFORMATION

Patient's Name: _____ DOB: ____/____/____ Age: _____ Sex: _____

Address: _____
Street City Zip Code

Marital Status (Circle one): Single Married Separated Divorced Widowed

Home Phone: _____ Cell:_____ _ Work:_____

Employer: _____ Occupation: _____

Spouse's Name _____ Occupation: _____

Employed by: _____ Work Phone: _____

Preferred Contact Method (check all that apply) Phone _____ Text _____ Email _____

Learned of Practice by: _____ Medical Insurance: YES NO

Social Security # _____-_____-_____ Driver's License # _____

Person to Contact in case of Emergency_____

Phone: _____

CREDIT CARD AUTHORIZATION (Optional)

If you wish Dr. Wise to file for direct reimbursement by your insurance company or if you prefer your charges to be made to your bank card account, please provide the information requested below. Your signature will be your authorization to Dr. Wise to charge your credit account for any balance not payable by insurance benefits. You will be notified of any charge made to your account. If your account should be overpaid you will be informed and a reimbursement will be made to you at your request.

Credit Card: Mastercard Visa Discover Amex

Account Number: _____

Card Expiration Date: _____/_____security code (_____)_____

Name Appearing on Card: _____

Signature: _____

ASSIGNMENT OF INSURANCE BENEFITS

(Do <u>not</u> provide insurance information if you do not want Dr. Wise to file your claims with your insurance company).

I hereby assign payment of medical benefits by:

_____
(Name of Insurance company)

_____
(Insured's Name)

_____ _____ _____
Insured's Social Security # Insured's I.D.# Insurance Group #

to Kenneth F. Wise, Psy.D. I also authorize the release of any medical information requested by the above-named insurance or managed health care company to the extent allowed by law. I understand that such information may include information identifying myself and the insurance holder, as well as my symptoms, general functioning, diagnosis, and general supportive data. The assignment and release will remain in effect, but may be revoked by me in writing, at any time except to the extent that action has previously been taken thereupon. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance company except to the extent that a contract between the provider and a managed health care company might limit that financial responsibility.

_____ _____
Signature Date

CONSENT AND AUTHORIZATION FOR THERAPIST TO COMMUNICATE WITH PRIMARY CARE PHYSICIAN

If you consent to allow Dr. Wise to communicate with your primary care physician regarding your case, please sign below. Your signature will indicate your consent and authorization until this office is given notice that you are withdrawing your consent and authorization for communication.

_____ (_____)_____
Name of Physician Telephone

_____
Physician's Address

_____
Signature

Patient History Form—Adult

Instructions: To assist Dr. Wise in helping you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to you, leave them blank.

Personal History

1) Name: _____ 2) Age: _____ 3) Gender: ___M ___F

4) Address: _____
Street & Number City State Zip

5) Weight: _____ 6) Height: _____ 7) Eye color: _____ 8) Hair color: _____ 9) Race: _____

10) Today's Date: _____ 11) Date of Birth: _____ 12) Years of education: _____

13) Occupation: _____ 14) Home Phone:_____ 15) Business Phone:_____

16) Present Marital Status:

_____ 1) never married
_____ 2) engaged to be married
_____ 3) married now for first time
_____ 4) married now after first time
_____ 5) separated
_____ 6) divorced and not remarried
_____ 7) widowed and not remarried
_____ 8) other (specify) _____

17) If married, are you living with your spouse at present?: Yes____ No____

18) If married, years married to present spouse: _____

Counseling History

19) Are you receiving counseling or psychiatric services at present?: Yes____No_____
If Yes, please briefly describe: _____
_____

20) Have you ever received counseling or psychiatric services in the past?: Yes_____No_____
If Yes, please briefly describe: _____
_____

21) What is (are) your main reason(s) for scheduling this visit?: _____
_____
_____

22) How long has this problem persisted (from #21)?: _____
_____

23) Under what conditions do your problems usually get worse?: _____
_____

24) Under what conditions are your problems usually improved?: _____
_____

25) How did you hear about Dr. Wise, or who referred you?: _____
_____

Medical History

26) Name and address of your primary physician:
Physician's name: _____
Address: _____

27) List any major illnesses and/or operations you have had: _____
_____

28) List any physical concerns you are having at present: (e.g., high blood pressure, headaches, dizziness, etc.): _____
_____

29) List any other physical or medical concerns you have experienced in the past: _____
_____
_____

30) When was your most recent complete physical exam?: _____
Results of physical exam: _____
_____

31) On average how many hours of sleep do you get daily?: _____

32) Do you have trouble falling asleep at night?: __No __Yes If Yes, describe _____
_____

33) Have you gained/lost over ten pounds in the past year?: __Yes __No, __gained __lost
If Yes, was the gain/loss on purpose?: __Yes __No

34) Describe your appetite (during the past week):
_____ poor appetite _____ average appetite _____ large appetite

35) What medications (and dosages) are you taking at present, and for what purpose?:
Medication Purpose
_____
_____
_____
_____

Have you ever been treated for stress or "nervous" disorders? __ Yes __ No

If yes, what were you treated for and what was the nature of the treatment? _____

_____

Have you previously been seen for counseling or therapy as an adult or when you were a child (either individually or with someone else)? ____Yes ____No

Which of the following have you consumed in the last six months?

Alcohol__Yes __No If yes, how much and how often? _____

Nicotine__Yes __No If yes, how much and how often? _____

Other Drugs__Yes __No If yes, what, how much, _____

and how often? _____ Have you or others ever been concerned about your alcohol or other substance use? _____Yes ____No

Have you ever experienced any legal consequences due to alcohol or drug use/possession? ___ Yes ___ No

Are you presently concerned about your alcohol or other substance use? ____Yes ____No

If yes, what are your concerns and how serious are they? _____

_____

Have you ever been the victim of violence or experienced traumatic events? _____

_____

Family History

36) Mother's age:_____ If deceased, how old were you when she died?: _____

37) Father's age:_____ If deceased, how old were you when he died?: _____

38) If your parents are separated or divorced, how old were you then?: _____

39) Number of brother(s) _____ Their ages _____ _____ _____ _____ _____ _____

40) Number of sister(s) _____ Their ages _____ _____ _____ _____ _____ _____

41) I was child number _____ in a family of _____ children.

42) Were you adopted or raised with parents other than your natural parents?: Yes___ No ___

43) Briefly describe your relationship with your brothers and/or sisters: _____
_____
_____
_____

44) Which of the following best describes the family in which you grew up?:

WARM AND ACCEPTING				AVERAGE				HOSTILE AND FIGHTING
1	2	3	4	5	6	7	8	9

45) Which of the following best describes the way in which your family raised you?:

ALLOWED ME TO BE VERY INDEPENDENT				AVERAGE				ATTEMPTED TO CONTROL ME
1	2	3	4	5	6	7	8	9

Thoughts and Behaviors

Please check how often the following thoughts occur to you:

1)	Life is hopeless.	____Never	____Rarely	____Sometimes	____Frequently
2)	I am lonely.	____Never	____Rarely	____Sometimes	____Frequently
3)	No one cares about me.	____Never	____Rarely	____Sometimes	____Frequently
4)	I am a failure.	____Never	____Rarely	____Sometimes	____Frequently
5)	Most people don't like me.	____Never	____Rarely	____Sometimes	____Frequently
6)	I want to die.	____Never	____Rarely	____Sometimes	____Frequently
7)	I want to hurt someone.	____Never	____Rarely	____Sometimes	____Frequently
8)	I am so stupid.	____Never	____Rarely	____Sometimes	____Frequently
9)	I am going crazy.	____Never	____Rarely	____Sometimes	____Frequently
10)	I can't concentrate.	____Never	____Rarely	____Sometimes	____Frequently
11)	I am so depressed.	____Never	____Rarely	____Sometimes	____Frequently
12)	God is disappointed in me.	____Never	____Rarely	____Sometimes	____Frequently
13)	I can't calm down.	____Never	____Rarely	____Sometimes	____Frequently
14)	Why am I so different?	____Never	____Rarely	____Sometimes	____Frequently
15)	I can't do anything right.	____Never	____Rarely	____Sometimes	____Frequently
16)	People hear my thoughts.	____Never	____Rarely	____Sometimes	____Frequently
17)	I have no emotions.	____Never	____Rarely	____Sometimes	____Frequently
18)	Someone is watching me.	____Never	____Rarely	____Sometimes	____Frequently
19)	I hear voices in my head.	____Never	____Rarely	____Sometimes	____Frequently
20)	I am out of control.	____Never	____Rarely	____Sometimes	____Frequently

Please comment (e.g., examples, frequency, duration, effects on you) about each of the above thoughts that occur frequently or are a concern to you. Use the back of this sheet if necessary.

_____

_____

_____

_____

_____

Symptoms

Check the behaviors and symptoms that occur to you more often than you would like them to take place:

_____ aggression	_____ fatigue	_____ sexual difficulties
_____ alcohol dependence	_____ hallucinations	_____ sick often
_____ anger	_____ heart palpitations	_____ sleeping problems
_____ antisocial behavior	_____ high blood pressure	_____ speech problems
_____ anxiety	_____ hopelessness	_____ suicidal thoughts
_____ avoiding people	_____ impulsivity	_____ thoughts disorganized
_____ chest pain	_____ irritability	_____ trembling
_____ depression	_____ judgment errors	_____ withdrawing
_____ disorientation	_____ loneliness	_____ worrying
_____ distractibility	_____ memory impairment	_____ other (specify)
_____ dizziness	_____ mood shifts	_____
_____ drug dependence	_____ panic attacks	_____
_____ eating disorder	_____ phobias/fears	_____
_____ elevated mood	_____ recurring thoughts	_____

Please give examples of how each of the symptoms that you checked impairs your ability to function (e.g., socially, emotionally, occupationally, physically, etc.). Use the back of this sheet if necessary.