CLIENT INFORMATION

PATIENT NAME : _____
(LAST NAME) (FIRST NAME) (MI)

SSN: _____ - _____ - _____

DATE OF BIRTH : _____ / _____ / _____

SEX : _____

ADDRESS : _____

APT # : _____

CITY : _____

STATE : _____

ZIP CODE : _____

HOME PHONE : (____) _____

WORK PHONE : (____) _____

CELL PHONE : (____) _____

EMAIL : _____

WOULD YOU LIKE TO RECEIVE EMAIL STATEMENTS ? YES NO

INSURANCE INFORMATION (please provide CARD for copying)

INSURANCE COMPANY : _____

INSURANCE COMPANY ADDRESS :_____

INS. ID # : _____

POLICY GROUP # : _____

PLAN NAME : _____ INSURANCE CO. TEL. # : _____

INSUREDS NAME : _____

PATIENT RELATIONSHIP TO INSURED : _____

EMERGENCY CONTACT INFORMATION

CONTACT NAME :_____

CELL PHONE : (____) _____

HOME PHONE : (____) _____

AUTOMATIC BILLING AUTHORIZATION FORM
(Not Required)

I authorize you to charge my bill from David Stroud, PLLC, directly to my credit card(s) listed below. These charges include, but are not limited to:

x Sessions – individual or group
x Phone Sessions
x Court Appearances and associated fees
x Late cancellations or missed appointments
x Supplements

This authorization is valid until I provide you with WRITTEN cancellation.

Client Name: _____ (Please PRINT)

I do NOT accept American Express at this time.

Name on credit card – exactly as printed
Billing Address for credit card (Street, Apt #)
City, State Zip:
Credit card #
Expiry Date :
Signature :
Today's Date :

REFERRAL SOURCE :

CLIENT NAME:

PHONE NO :

ADDRESS:

Effective treatment begins after an accurate diagnosis has been made. This form is crucially important in making the correct assessment. Please answer the following questions as completely as possible. Feel free to write on the back or add additional pages as necessary.

CC: What is your chief concern at this time? : _____

_____

_____

What stressful events have recently occurred? : _____

_____

_____

HPI: Please describe in detail the symptoms you have experienced :_____

_____

When would you estimate that these symptoms began: _____

_____

What has been the course of your symptoms? (i.e. getting better, worse or staying the same and give the time frame) : _____

_____

Have you experienced similar symptoms before? (Please describe and give the time frame) : _____

_____

What have you tried that has made the symptoms better : _____

_____

What have you tried that has made the symptoms worse? : _____

_____

Please circle your answer and describe any Yes answers to the questions below.

Consistently down or depressed mood most of the day, nearly every day?	Yes	No
Diminished level of interest or pleasure in most or all activities?	Yes	No
Change in appetite?	Yes	No
Change in weight ?	Yes	No
Change in sleep pattern?	Yes	No
Feeling agitated of slowed down?	Yes	No
Fatigue or loss of energy?	Yes	No
Feelings of worthlessness or excessive guilt?	Yes	No
Difficulty thinking or concentrating?	Yes	No
Change in sex drive?	Yes	No
Irritability, rage or violent behavior?	Yes	No
Attacks of hyperventilation, palpitations or intense fear?	Yes	No
Change in drinking / drug use pattern?	Yes	No
Thoughts of death or suicide (or any attempts)?	Yes	No
Do you have access to any firearm (handgun, rifle, shotgun, etc.)?	Yes	No

PMH: Psychiatric

Any prior psychiatric evaluation? Please name the treating psychiatrist, dates of treatment, diagnosis, treatment response : _____

_____

Any prior psychiatric hospitalization? Give name of hospital, psychiatrist, dates, treatment and response : _____

_____

Have you ever been in therapy? Give name of therapist, dates and describe the issues that were addressed : _____

_____

Please list all the psychiatric medication (for depression, anxiety, insomnia, etc.) you have ever taken. Please describe any benefits or side effects that you experienced : _____

_____

Have you ever planned or made a suicide attempt? Please describe in detail : _____

_____

Any phobias or unusual fears?_____
_____

Ever experience auditory or visual hallucinations? _____
_____

Ever experience a "natural high" in absence of substance abuse (with increased energy, mood, talkativeness, decreased need for sleep, etc.)? : _____

For Women Only: Ever notice any change in mood or behavior after giving, birth or premenstrual ? Please give details : _____

PMH: CD
It is important to give honest estimates of your intake of the following:

Nicotine: _____

Packs per day: _____

Years of smoking: _____

Caffeine: Daily intake of coffee, tea, cola drinks or caffeine pills: _____
Alcohol:

Highest intake in 24 hour day: _____

Current weekly number of drinks: _____

Past:_____

Ever miss work or school due to being hung over, ever have any blackouts, accidents, legal (DWI, PI), health, marital or other problems? Please circle and describe : _____
_____

Other: Marijuana, cocaine, amphetamines, LSD, heroin (or other IV drugs), mushrooms, ecstasy, inhalants, prescription narcotics or other substances. Please circle and describe : _
_____

PMH: ED
Height: _____ Weight: _____ Highest Weight: _____Lowest Weight: _____
Any history of food binging?
Any use of laxatives, diuretics, diet pills, purging or food restriction for weight control? Please circle and describe : _____

OCD: Ever experience persistent obsessive thoughts or images of contamination, aggressive, sexual or religious fantasy or pathological doubt? : _____

Ever experience persistent compulsive behaviors, cleaning / washing, checking, counting, tapping, touching, repeating or arranging / ordering?: _____

OSA: Have you ever been informed that you snore loudly or that you stop breathing while sleeping, or wake up gasping for breath?: _____

PMH: Medical / Surgical

Personal physician(s), list name(s) and phone number(s): _____

_____

Date of most recent exam / lab work : _____

Any other health care provider you see (chiropractor, physical therapist, etc.) : _____

_____

Give details of any major medical problems you have (i.e. heart disease, high blood pressure, diabetes, thyroid disease, etc.) : _____

_____

Any prior surgeries (give date, type and any complications)? : _____

_____

Any prior hospitalizations (give date, reason, type of treatment)? : _____

_____

Any prior injuries, falls or accidents (especially any that resulted in a loss of consciousness of 5 minutes or longer)? : _____

Have you ever had a seizure or seizure disorder? : _____

Have you ever had a MRI or CAT Scan of the head? Give date and findings. : _____

_____

List all medications you currently or have recently taken (include over-the-counter coeds).
Give details:

Medication Name	**Dosage**	**Duration of usage**

List any allergic reactions you have had to any medications, foods or other substances :

_____

_____

FH:

Research has shown that heredity is important in many psychiatric disorders. Please take the time to think of your various blood related kin. Indicate any who have had similar symptoms as yourself. Also, note if any had problems (even if no treatment was received) with the following: - anxiety, depression, manic depression, post partum depression, changes in behavior or mood, eating disorders, phobias, suicidal behavior, drug or alcohol dependency, schizophrenia or Alzheimer's disease. Please note any other psychiatric or known medical problems.

RELATIVE **PROBLEM**

_____

_____

_____

_____

_____

Describe your current relationship with your family : _____

_____

_____

Marriage (s) or other long-term relationships. Give duration and describe relationship:_____

_____

Describe your children (list according to name and age) : _____

_____

Level of education : _____

Occupation : _____

Length of employment: _____

Describe work situation : _____

Current / past legal problems?: _____

Religious affiliation : _____

Military service : _____

Special interests or hobbies : _____

Number of hours spent exercising per week: _____

Type of exercise (i.e. running, walking, aerobics, weight lifting): _____