# FREMOUW-SIGLEY PSYCHOLOGICAL ASSOCIATES, PLLC

**Independent Licensed Psychologists**

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## CLIENT INFORMATION

Name: _______________________________________ Date: __________________ Sex: M___F___

Birth Date: ____ ____ ____ Address: __________________________________________________________

City: __________________________________________ State: _______________ Zip: ___________________

Phone: ________________________ Cell: _____________________ Next of Kin: ______________________

Relationship: ____________________________ Phone of Kin: _____________________________________

Address of Kin: _____________________________________________________________________________

## IF CLIENT IS LESS THAN 18 YEARS OLD

Check (x) legal custodian of child: Parents_____ DHHR______ Others (please specify) ________________

If joint custody exists, **both** parents must consent to non-emergency medical/psychological care. Bring a copy of the divorce-parenting plan prior to the start of services.

Print name of each parent: _________________________________ _________________________________

## PRIMARY HEALTH INSURANCE INFORMATION

Name of Policy Holder: ___________________________________ Birth Date of Policy Holder: ___ ___ ___

Address of Policy Holder: ____________________________________________________________________

Sex: M____ F____ Relationship to Policy Holder: Self____ Spouse _____ Child _____ Other _____

Insurance Company Name: ___________________________________________________________________

Insurance Mailing Address: ___________________________________________________________________

ID Number: _______________________ Group Number: ________________ Ins. Co. Phone: ___________

Employer: ________________________ Ins. Phone Number for Mental Health: _______________________

**Is there another health benefit plan? Yes ____ No _____**

## SECONDARY HEALTH INSURANCE INFORMATION (PROVIDE TO RECEPTIONIST)

Name of Other Insured: ______________________________ Date of Birth: ____ ____ ____

Other Insurance Company Name/Address: _____________________________________________________________

## CONTACT INFORMATION AND PERMISSION

Email: ________________________________

I authorize: (Please indicate YES or NO for each option)

YES NO Leave a message on my home answering machine

YES NO Leave a message on my work voicemail

YES NO Leave a message on my cell phone voicemail

YES NO Leave a message with a family member/ friend at my home

YES NO Leave a message with all family members/friends

Only the following: ________________________________

YES NO Contact me by mail at the following address (to include billing): ____________________

________________________________________________________________________________

## BASIC BACKGROUND INFORMATION

☐ I received an informed consent form and was given the opportunity to ask questions.

My marital status:

☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Separated ☐ Other

Spouse/Partner's First/Last Name: ________________________________________________

Children (First name, age): ________________________________________________

Religious Affiliation: ________________________________________________

Military History: ________________________________________________

Persons living in my home: ________________________________________________

Work Status: ________________________Education: Highest grade completed ________________
Degree:________________ Other: ______________

What type of work do you do?____________________________________________ How long? _____________

## YOUR COUNSELING HISTORY, NEEDS AND GOALS

What is your most pressing reason for seeking counseling? ____________________________________

________________________________________________________________________________

What are your other concerns: ________________________________________________

________________________________________________________________________________

How did you find out about our practice? ☐ Website ☐ Search Engine ☐ Friend

Is Counseling or Evaluation Requested? ☐ Evaluation ☐ Counseling

**Please tell me about your previous counseling or psychological/educated evaluations:**

| Provider | Where | When | How Long | Type of Evaluation | Useful Y/N |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

Are you or your child currently having suicidal thoughts: ☐ Yes ☐ No

If yes, please describe: ______________________________________________________________

Have you or your child ever made a suicide attempt? ☐ Yes ☐ No When? ______________________

If yes, please explain: ______________________________________________________________

Has anyone related to you made a suicide attempt or completed suicide? ☐ Yes ☐ No

If yes, please explain: ___________________________________ When? ______________________

Are you or is your child currently having homicidal thoughts? ☐ Yes ☐ No

If yes, please explain: ______________________________________________________________

Have you or anyone related to you ever attempted a homicide? ☐ Yes ☐ No When? _____________

If yes, please explain: ______________________________________________________________

Do you worry about your safety in your current living situation? ☐ Yes ☐ No

If yes, please explain: ______________________________________________________________

Have you or your child ever struck or threatened people or animals or broken things in your home?

☐ Yes ☐ No If yes, please tell me about it:

_____________________________________________________________________________________

What are you or your child's strengths? (check all that apply)

| | | | |
|---|---|---|---|
| ☐ Bright | ☐ Insightful | ☐ Motivated | ☐ Active |
| ☐ Have self-control | ☐ Have Friends | ☐ Can calm myself | ☐ Mostly healthy |
| ☐ Can ask for help | ☐ Keep my boundaries | ☐ Have moral ethics | ☐ Can solve problems |
| ☐ Can forgive | ☐ Can express feelings | ☐ Have enough money to meet my needs | ☐ Resourceful |
| ☐ Sense of humor | ☐ Compassionate | ☐ Patient | ☐ Good Listener |
| ☐ Stable Employment | ☐ Satisfied with employment | ☐ Willing to learn new attitudes and behaviors | ☐ Can accept love and care for others |

## YOUR SOCIAL HISTORY

How often have you been married and for how long?

______________________________________________________________________________

Is there anything unusual about your childhood that I should know?

______________________________________________________________________________

Please list significant traumatic events:

______________________________________________________________________________

Please list significant losses: _______________________________________________________

Please list your brothers and sisters and their ages:

______________________________________________________________________________

Please describe any significant legal history (i.e. arrest, bankruptcy)

______________________________________________________________________________

______________________________________________________________________________

Is there anything else significant that you want me to know?

______________________________________________________________________________

______________________________________________________________________________

## CURRENT SYMPTOMS

Current Symptoms: (Please check all that apply & leave lines blank.)

- ☐ Depression ___________________
- ☐ Sleep Change _________________
- ☐ Appetite Change _______________
- ☐ Crying ______________________
- ☐ Energy Level___________________
- ☐ Weight Change ________________
- ☐ Poor Concentration _____________
- ☐ Memory Problems ______________
- ☐ Pain ________________________
- ☐ Suicidal Thoughts ______________
- ☐Thought to Harm Others __________
- ☐ Irritability______________________
- ☐ Confusion ____________________
- ☐ Anxiety_______________________
- ☐ Anger Problem _________________
- ☐ Impulsivity ____________________
- ☐ Family Conflict ________________
- ☐ School Problems__________________
- ☐ Panic __________________________
- ☐ Self-injuries _____________________
- ☐ Racing Thoughts __________________
- ☐ Hearing Voices ____________________
- ☐ Seeing Things ____________________
- ☐ Odd Beliefs ______________________
- ☐ Paranoia _________________________
- ☐ History of abuse ___________________
- ☐ Nightmares ________________________
- ☐ Avoiding people/places _____________
- ☐ Preoccupations/rituals ______________
- ☐ Running Away ______________________
- ☐ Sexual Problems ____________________
- ☐ Mood Swings _______________________
- ☐ Loss of Pleasure_____________________
- ☐ Reckless Behaviors___________________

## MEDICAL HISTORY

Family or Primary Care Physician: ____________________________________________________________

Date of last physical examination ____________________________________________________

Please check any illness you or your child currently have or have had in the past:

| | | | |
|---|---|---|---|
| ☐ Diabetes | ☐ High Blood Pressure | ☐ Lung Disease | ☐Venereal Disease |
| ☐ Asthma | ☐ Low Blood Pressure | ☐ Cancer | ☐ Head Injuries |
| ☐ Arthritis | ☐ Heart Disease | ☐ Kidney Disease | ☐ Injuries |
| ☐ Anemia | ☐ Tuberculosis | ☐ Cirrhosis | ☐ Muscular Disorder |
| ☐ Ulcer | ☐ Colitis | ☐ Bone Disorder | ☐ Obesity |
| ☐ Seizures | ☐ Nerve Disorder | ☐ Anorexia | ☐ AIDS/HIV |
| ☐ Alcohol/ Drug Problems | ☐ Migraines | ☐ Urinary Tract Infection | ☐ Headaches |
| ☐ Constipation | | | |

Is there any history of depression, mental illness, or alcohol/drug problems in your family of origin?

☐ Yes ☐ No If yes, please explain:

______________________________________________________________________________

Do you have any history of depression, anxiety, or mental illness? ☐ Yes ☐ No If yes, please explain:

______________________________________________________________________________

Please tell me about past hospitalizations (include psychiatric or substance abuse treatment):

| Date | Reason | Hospital | Physician |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Are you or your child taking any medications now? ☐ Yes ☐ No If yes, please list below and include any over the counter

medicines taken regularly:

| Medication | Dosage | How often? | Reason for Medication |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Do you take supplements or herbs routinely? ☐ Yes ☐ No If yes, please list below:

| Supplement/ Herb | Dosage | How often? | Reason for Use |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Do you or your child have allergies? ☐ Yes ☐ No If yes, please explain:

_____________________________________________________________________________________

Please tell me how much caffeine you consume:
Estimated daily consumption of coffee or tea: ____________cups/day
Estimated daily consumption of soda or pop: ____________ounces/day

## SUBSTANCE USE INFORMATION

Do you or your child have a history of IV drug use? ☐ Yes ☐ No

Have you ever felt you or your child needed to cut down on your drinking? ☐ Yes ☐ No

Have people annoyed you by criticizing your drinking? ☐ Yes ☐ No

Have you or your child ever felt guilty about drinking? ☐ Yes ☐ No

Have you ever felt you needed a drink first thing in the morning (eye-opener) to steady your nerves or to get rid of a hangover? ☐ Yes ☐ No

Do you drink socially? ☐ Yes ☐ No If yes, how often?_________ how much? ________

How old were you when you took your first drink?_________

Have you ever attended: ☐ A.A. ☐ Alanon ☐ N.A. Have you ever had a D.U.I? ☐ Yes ☐ No

If yes, how many_______? Have you ever been arrested for a drinking or drug-related offense of any kind? ☐ Yes ☐ No
If yes, please explain______________________________________________________________________

_____________________________________________________________________________________

## CLIENT SIGNATURE

Signature of the client or authorized person allows release of information necessary to process insurance claims and authorizes direct payment of health insurance benefits to Fremouw-Sigley Psychological Associates. THIS INFORMATION WILL INCLUDE DIAGNOSIS, DATES OF TREATMENT, CPT BILLING CODES, AND SOMETIMES TREATMENT PLAN.

________________________________________ ________________________________

Signature Date