Ellen Connell, Psy.D.

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New Patient Information

Patient Name_____ Sex _____ Age_____ DOB ___/___/___
Address_____
Phone _____ May I leave a voicemail? Y___ N____
Email _____ May I e-mail you? Y ___ N ____

How did you hear about my practice? _____

Emergency Contact: _____
Relationship to patient: _____
Phone #(s)_____

RESPONSIBLE PARTY FOR BILL (if other than patient): Name_____
Relationship to patient _____
Address_____
Phone # _____

INSURANCE INFORMATION:
Company_____
Address_____
Phone # _____

Name on insurance card _____

Insured's Relationship to Patient: Self ( ) Spouse ( ) Child ( ) Other ( )

Insured ID#_____ Group or Plan # _____

Effective Date of Insurance _____

By signing below, I agree to pay a fee of $____ per hour to Ellen Connell, Psy.D. for services provided. I understand that this fee is subject to change, and that any change in fee will be as mutually agreed upon. I understand that my fee is subject to periodic review, particularly if my financial situation changes and I am paying a reduced fee. I agree to pay for services at the time they are provided, or as frequently as mutually agreed upon. If I am utilizing my health insurance to receive reimbursement for these services, I authorize release of the information necessary to process a claim with my insurance company. I understand that my health insurance cannot be billed for missed appointments. I agree to pay a full session fee for appointments missed without providing 24 hours notice.

Signature _____ Date _____

(If a minor, parent or guardian must also sign.)

Signature _____ Date _____

Intake Questionnaire

DEMOGRAPHIC INFORMATION:

Age: _____ Race/Ethnicity: _____ Marital Status: _____
Highest grade/degree completed _____

College/Graduate Major(s): _____ Occupation: _____
Please describe your current living situation, including any family members or roommates living with you: _____
_____

Do you have any children? □ No □ Yes If so, what are their ages and sexes?
_____

Are you currently in a romantic relationship? □ No □ Yes If yes, for how long? _____

If yes, on a scale of 1-10, how would you rate your satisfaction with the relationship? _____

Chief Concern: Briefly summarize your reason(s) for beginning therapy:
_____
_____

Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION Have you previously received any type of mental health services (therapy, psychiatry, etc.)? □ No □ Yes,

If Yes, Previous therapist/practitioner: _____

Dates/ Length of Treatment: _____

Have you ever been hospitalized for emotional/psychiatric reasons? □ No □ Yes,

Hospital/Date/Length of Stay: _____

Are you currently taking any prescription medication? □ Yes □ No

If Yes, Please list: _____
_____

If not currently taking medication, have you ever been prescribed psychiatric medication? □ Yes □ No
Please list and provide dates: _____
_____

How would you rate your current physical health?

(Please circle) Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing: _____
_____

When did you have your last physical/medical exam? _____

Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe:_____

Do you have allergies? □ No □ Yes If yes, please list:_____

In Childhood, did you experience any developmental delays, learning disorders, or other issues? If yes, please describe: _____

Have you experienced any physical or emotional trauma which has impacted your physical or mental health? If yes, please share (if you think it will be helpful for me to know).

_____
_____

SUBSTANCE USE:

How many drinks of alcohol do you consume in a typical week? _____

How much tobacco do you smoke or chew each week? _____

How many caffeinated beverages do you drink each day? _____

How much marijuana do you smoke/consume in a typical week? _____

How often do you use other recreational drugs? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

Please describe type and frequency of use: _____

FAMILY MENTAL HEALTH HISTORY:

Have any of your biological relatives ever had any of the following?

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	_____
Anxiety	yes/no	_____
Depression	yes/no	_____
Domestic Violence	yes/no	_____
Eating Disorders	yes/no	_____
Obsessive Compulsive Behavior	yes/no	_____
Psychiatric Treatment	yes/no	_____
Schizophrenia	yes/no	_____
Suicide Attempts	yes/no	_____

CHECKLIST OF CONCERNS:

Please mark all of the items below that apply. Feel free to add in others at the bottom.

____ Abuse—physical, sexual, emotional, neglect
____ Alcohol use
____ Anxiety/Worry
____ Career concerns
____ Compulsions
____ Cutting/Self-Injury
____ Depression, sadness, tearfulness
____ Drug use
____ Family problems
____ Gambling
____ Guilt
____ Impulse control
____ Legal concerns
____ Marital concerns
____ Mood swings
____ Obsessive thoughts
____ Panic or anxiety attacks
____ Phobias
____ Relationship problems
____ Self-neglect, poor self care
____ Sleep (insomnia, nightmares, too much sleep)
____ Spending sprees
____ Suspiciousness
____ Thought disorganization, confusion
____ Withdrawal, isolation
____ Aggression
____ Anger outbursts, temper problems
____ Attention, concentration, distractibility
____ Codependence
____ Custody of children
____ Delusions
____ Divorce, separation, breakup
____ Eating concerns
____ Flashbacks of traumatic event
____ Grieving
____ Health Concerns
____ Interpersonal conflict
____ Loneliness
____ Memory problems
____ Nervousness
____ Pain (headaches, backaches, etc.)
____ Perfectionism
____ Police/Probation involvement
____ Self-esteem
____ Sexual concerns
____ Smoking/tobacco use
____ Stress, relaxation, tension
____ Suicidal thoughts
____ Weight and diet concerns
____ Work problems

Other concerns not listed:

Looking back over the concerns you have checked, which concern would you most like to address in therapy? _____

Have you ever had had any thoughts of wanting to harm yourself? □ Yes □ No

Have you ever had any thoughts of wanting to harm someone else? □ Yes □ No

Have you ever seen or heard things that others can't see or hear? □ Yes □ No

ADDITIONAL INFORMATION: What do you consider to be some of your strengths?

_____

What do you consider to be some of your weaknesses?

_____

What would you like to accomplish during your time in therapy?

_____