PERSONAL INFORMATION FORM – ADULT

Today's date: _________ Client's name: ____
DOB: __________SS#:______-____-______Marital status:______________________________
Client's address:____
Client's phone#: Home:______________________Work:_______________________________
Employer:____
Position:____
Who referred you to Sadie:____
Referal source address:____
I understand I will be charged for missed appointments if the office is not notified 24 hours in advance. Please initial_________________

Permission to Send "Thank You" to Referral Source? Yes ☐ No ☐

SYMPTOM CHECK LIST: (Circle all that apply; Use blank space to add items not listed)

agitate	restless	anxious	racing thoughts
fearful	worry a lot	depressed	appetite increases
cry often	don't fit in	confused	appetite decreases
hopeless	helpless	sad	no appetite
withdrawn	guilt	suicidal	overly distracted
feel out of control	hear voices	personality changes	mood swings
suspicious	can't concentrate	overactive/rapid speech	homicidal
angry	irritable	passive	

How long have these symptoms been present? (Circle all that apply)

Less than a month | Several Months | Several Years | Since Childhood

SLEEP PATTERNS (Circle all that apply)

Awaken early	Insomnia	Hard to get to sleep	Sleep too much
Excessive fatigue	Night terrors	Sleep walking	Nightmares

Number of hours of sleep per night:____________

ENERGY LEVELS: (Circle one)

Tire easily   average energy   high energy

PRIMARY STRESSORS: (Circle major areas of stress)

Problems with family or friends   Not enough support people
Educational Stressors   Occupational stressors
Housing Problems   Economic/financial problems
Legal Issues   Other____

TREATMENT HISTORY

List any previous Psychiatric/Psychological Treatment or Counseling: None
When?____
By whom?____

CHEMICAL USE HISTORY:
(Circle yes or no)

Do you use Nicotine? YES   NO
If yes, how many packs per day?____
Do you use Caffeine? YES   NO
If yes, how much? ____
Do you use Alcohol? YES   NO
If yes, what do you drink?   Beer   Wine   Hard Liquor
How often do you drink alcohol?
Daily   3-5 times/week   1-2 times/week   less frequently
Do you use drugs?   YES   NO
If yes, what do you use?____
How often?____
Do you or any family members have a problem with alcohol or drugs?_____________________
____

FAMILY HISTORY

Spouse/Partner's Name:____________________________________DOB____________________
Number of children:____
Have any family members been in mental health treatment? YES NO
If yes, please specify:____
Have you ever been exposed to abusive behavior(s)? YES NO
If yes, please answer the following:

Past Abuse?	NO	YES	If yes, who was the abuser?__________________________
Curent Exposure	NO	YES	If yes, who is the abuser?____________________________

Type of abuse:	Physical	Sexual	Verbal
How experienced:	personally	witnessed	
Is/was it occurring:	Within the family	Outside the family	

Is there anything else you would like your Provider to know?______________________________

MEDICAL HISTORY

Primary Care Physician
Name:____Phone:_____________________
Address:____
Date of your last complete physical exam?____
Reason for exam?____

MEDICATIONS CURRENTLY BEING USED: (prescribed and/or over the counter)

None

Medication	Dosage	Frequency	Last Used	Prescribed by

VISUAL:

None	Wears Glasses	Glaucoma
Blurred vision	Other:_______________	

HEARING:

None	Dizziness	Ringing
Deafness	Hard of hearing	Other:_____________

RESPIRATORY:

None	Asthma	Hay Fever
Congestion	Short of Breath	Emphysema
Tuberculosis	Other:________________	

CARDIOVASCULAR

None	High BP	Low BP
Chest pain	Prior Stroke	prior Heart Attack

EXCRETORY

None	Urinary Problems	Bladder Problems
Other:___________		

NEUROLOGICAL

None	Seizures	Frequent Headaches
Migraines	Memory Problems	History of head injury

SEXUAL/ REPRODUCTIVE

Sexual Orientation (if information is helpful to your therapy)

Heterosexual	Homosexual	Bisexual
Other:___________		
Sexual worries	Birth control issues	PMS
Menopause		

ENDOCRINE

None	Diabetes
Hypoglycemia	Thyroid Problems

GASTROINTESTINAL

None	nausea / vomiting	Diarrhea
Ulcers	Constipation	Poor appetite
Ravenous appetite		

MUSCULOSKELETAL

None	Muscle impairment	Joint pain
Restricted Motion	Back pain	

CANCER None Type: ______________________________________

Year of Discovery: __________________

OTHER MEDICAL CONDITIONS/ SURGERIES

____

SERIOUS INJURIES:

____

CONSENT TO TREATMENT

1. I, ____, give my permission and consent to Mercedes M. Michael L.I.S.W. to provide mental health assessment / treatment to me and / or my child / family (if treatment is for you r child, please write in your child's name: ____).

2. I understand that treatment with this therapist will be confidential and a written and signed release will be required to disclose information, except under the following conditions:

2a. I understand that this therapist, as required by law, must report actual or suspected child or elder abuse to the appropriate authorities. In addition, this therapist has a legal responsibility to protect anyone threatened with violent, harmful or dangerous actions (including myself), and may break the confidentiality of our communication if such a situation arises. I understand that this therapist will make a reasonable effort to resolve these situations before breaking confidentiality.

2b. I have also reviewd information provided by this therapist regarding use of **protected health information (phi) per "HIPPA" (Health Insurance Portability and Accountability Act).** A written copy of the **Notice of Privacy Practices** will be given to me upon my request.

3. I understand I have the right to discontinue treatment at any time.
4. I understand that I have the responsibility to provide accurate and complete information in order for treatment to be appropriate and effective.
5. I understand that treatment goals may not be successfully achieved should I decide to discontinue treatment against the advice of my child's therapist.
6. PAYMENT: I understand that I am financially responsible for this treatment at a fee of $ 100 .00 per therapy session and agree to make payment / co-payment at the time of service.
7. I am responsible for obtaining necessary insurance authorization / referrals and for confirming coverage.
8. I acknowledge that although insurance will be billed directly, that I am responsible for the balance of my account for services rendered, regardless of any payments or promise for payment by my insurance company or other third party.
9. I understand that I am responsible for filing complaints or suits against my insurance company if they deny or delay paymenton an eligible visit.
10. I consent to the disclosure of necessary information to my insurance company, which is required for billing (diagnosis, treatment plans, dates of service, and, if required, treatment progress). I also give consent to bill my insurance company for services rendered.
11. I agree to notify the therapist of any changes in insurance coverage.
12. CANCELLATIONS: I understand that if the office is not notified 24 hours in advance of my intent to cancel, I will be charged a "missed appointment" fee of $70.00. I understand that insurance does not cover "missed appointment" fees.

13. There is a fee for all professional services rendered including written reports, letters, evaluations, depositions, testifying or time involved in a court appearance
14. I have had the opportunity to discuss this consent with my therapist and do hereby give full voluntary consent/ authorization to the treatment for myself and or my child/family under the conditions set forth above. This agreement is entered into in the city of Columbus, County of Franklin, State of Ohio.

____

Print name

____ ____________________

Signature Date